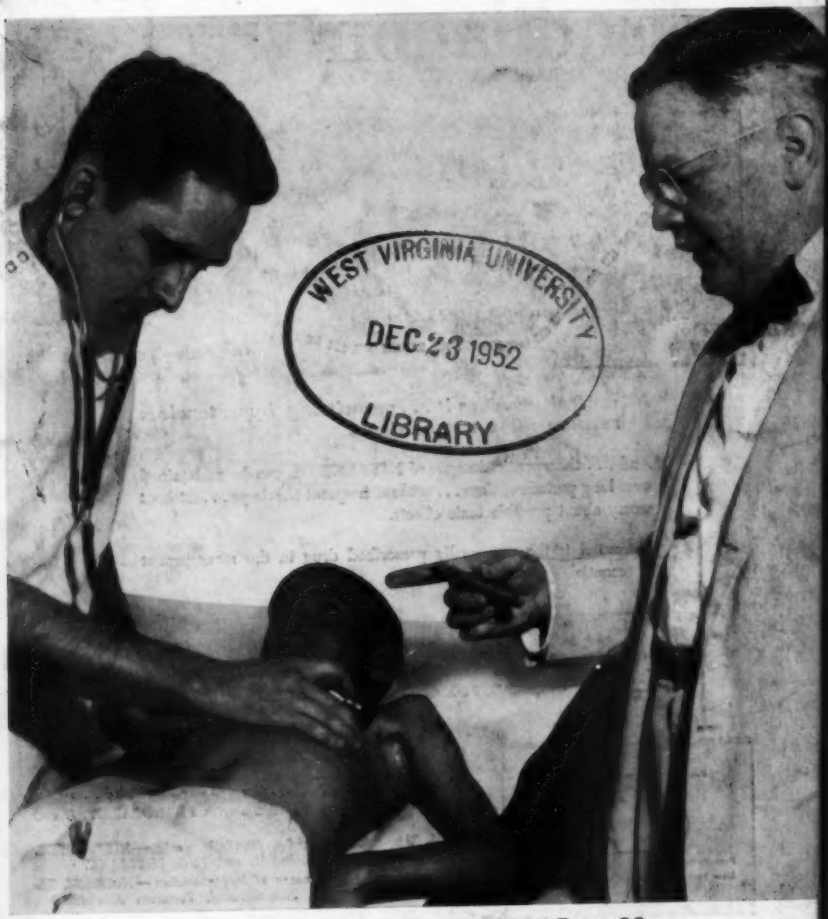
December

Medical Economics



Eleven Weeks at a G.P.'s Elbow • *Page 90*

Safe, gradual, prolonged vasodilation

Isn't that what you want for your hypertensive patients?

Nitranitol provides it . . . permitting hypertensives to resume more normal lives.

And . . . therapeutic dosages of NITRANITOL can be maintained over long periods of time . . . *without* frequent checkups . . . *without* worry about possible toxic effects.

Nitranitol is the universally prescribed drug in the management of essential hypertension.

NITRANITOL®

(brand of mannitol hexanitrate)

FOR SAFE, GRADUAL, PROLONGED VASODILATION

1. **When vasodilation alone is indicated**—*NITRANITOL.*
2. **When sedation is desired**—*NITRANITOL with PHENOBARBITAL.*
3. **For extra protection against hazards of capillary fragility**—*NITRANITOL with PHENOBARBITAL and RUTIN.*
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5. **For refractory cases of hypertension**—*NITRANITOL P.V. (Nitranitol, Phenobarbital, Veratrum Alkaloids*)*

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New! THE PERFECT PORTABLE REFRIGERETTE FOR A DOCTOR'S OFFICE!

"SERVEL Electric Wonderbar"

PORTABLE, SILENT REFRIGERETTE STYLED AS SMART FURNITURE

It keeps vaccines, antibiotics, biologicals and serums safe — and *handy!* Freezes ice cubes! Chills drinks and snacks for those long tough days when you can't get out of the office! All this in a sleek cabinet that's smart *anywhere!*

It takes no more space than a file cabinet — even fits on a table! Wheels wherever you want it!

It blends with any setting . . . comes in mahogany, blond or white . . can be painted to match your office.

5-year warranty on silent freezing system. Just plug in — AC or DC, 12 to 230 volts. Legs or casters optional. Ask our representative.

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The name to watch for great advances in
REFRIGERATION and AIR CONDITIONING
GAS • ELECTRIC

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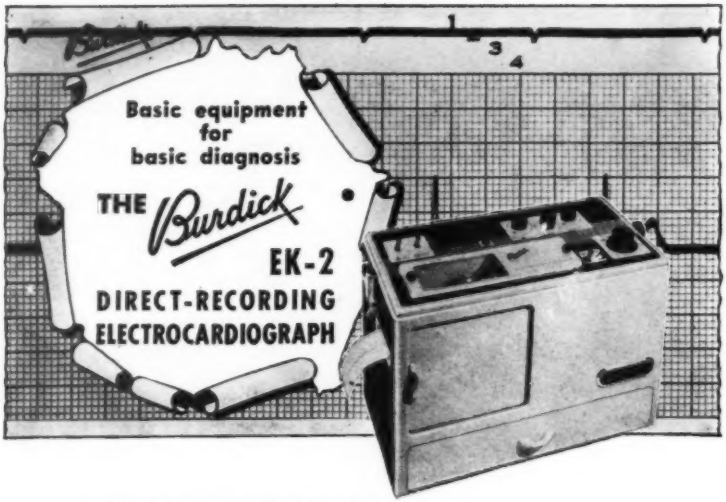
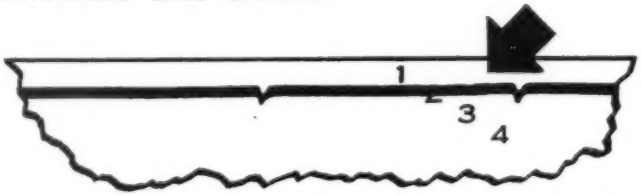


— with the special unique feature — a continuous, automatic time marker.



The lead selector switch permits choice of eleven positions including "Standardize", the three standard limb leads, chest lead, "V" (Wilson) lead and augmented (Goldberger) leads.

The combination of versatility and exactness make the Burdick EK-2 *a precision instrument.*

Easy control
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Medical Economics

* * * *December 1952* * * *

[CONTINUED ON FOLLOWING PAGE]

Contents [*Continued*]

CCA

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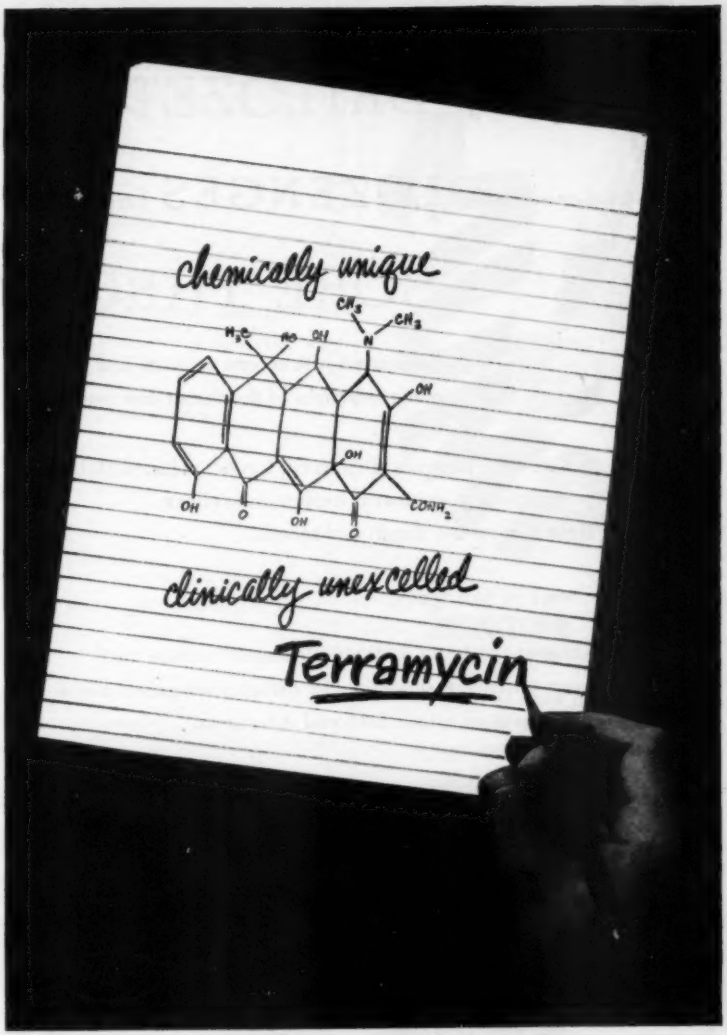

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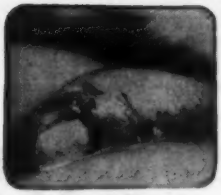
* Index of Advertisers *



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ECZEMATOID DERMATITIS

AFTER 10 DAYS' TREATMENT WITH VIOFORM

Vioform CREAM FOR eczema

Despite the diagnostic complexities of the many forms of eczema—acute, subacute, chronic, infectious, etc., treatment with Vioform Cream or Vioform Ointment is uniformly simple, convenient, and, above all, consistently effective. Vioform® (brand of iodochlorhydroxyquinoline) has been termed "one of the best antieczematous, mildly soothing . . . remedies."*

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*Sulzberger, Marion B., and Wolf, J.: Dermatologic Therapy in General Practice, ed. 3, Chicago, Year Book Publishers, Inc., 1948, p. 107.

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REFRACTORY CASES OF ANEMIA ARE A WARNING THAT MORE COMPLETE THERAPY IS NEEDED

Complete anemia therapy "...should include in adequate amounts all essential nutritive elements..."[1]

When the therapy is inadequate, the anemia is erroneously classified as "refractory." Investigation has revealed that so-called "refractory anemias" usually respond when all the necessary hemopoietic and nutritional factors are supplied. HEPTUNA PLUS contains Vitamin B_{12}, Ferrous Sulfate, Folic Acid, and Ascorbic Acid . . . for maximal hemoglobin synthesis and more effective hemopoiesis . . . PLUS other essential Vitamins, Minerals, and Trace Elements necessary for blood regeneration and for the maintenance of an optimal nutritive state.

Heptuna plus

For Complete Anemia Therapy

ALL IN ONE CAPSULE

FERROUS SULFATE U.S.P.	4.5 gr.
VITAMIN B12	5.0 mcg.
FOLIC ACID	0.33 mg.
ASCORBIC ACID	50.0 mg.
COBALT	0.1 mg.
COPPER	1 mg.
MOLYBDENUM	0.2 mg.
CALCIUM	37.4 mg.
IODINE	0.05 mg.
MANGANESE	0.033 mg.
MAGNESIUM	2 mg.
PHOSPHORUS	29.0 mg.
POTASSIUM	1.7 mg.
ZINC	0.4 mg.
VITAMIN A	5,000 U.S.P. UNITS
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THIAMINE HYDROCHLORIDE	2 mg.
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CALCIUM PANTOTHENATE	0.33 mg.

With other B-Complex Factors from Liver

1. McLester, J. S.: Nutrition and Diet in Health and Disease. Ed. 5 (Philadelphia: W. B. Saunders and Co.) 1949, p. 636.

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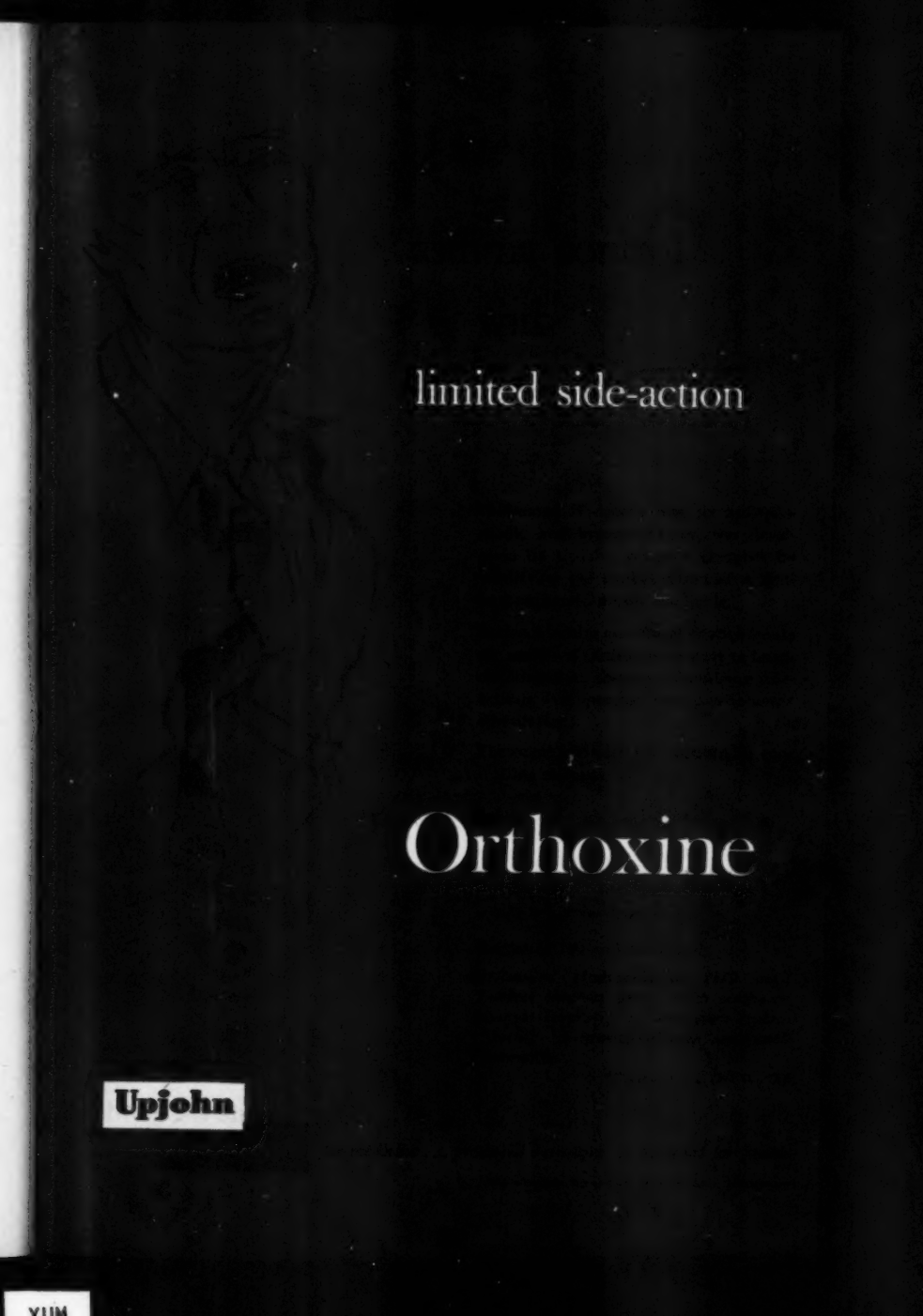
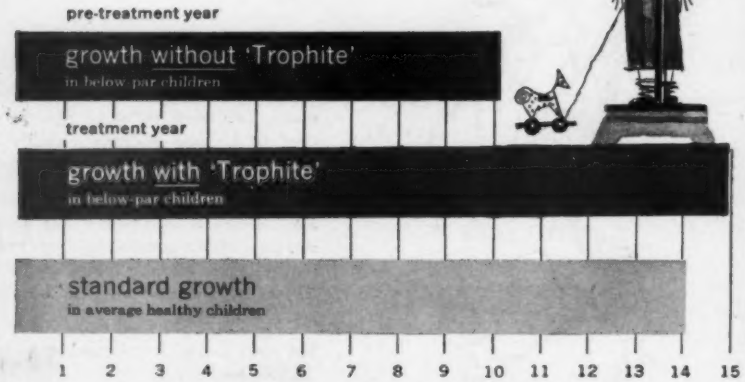
536 LAKE SHORE DRIVE, CHICAGO 11, ILL.


limited side-action
Orthoxine
Upjohn

how 'Trophite' increased growth

in a one-year clinical trial



Average Development Rate—Levels/Year (Wetzel Units)
These levels represent growth in terms of both height and weight.

FORMULA: Each *delicious* teaspoonful supplies Vitamin B_{12}, 25 mcg.; and Vitamin B_1, 10 mg.

DOSAGE: *One teaspoonful daily.* If desired, 'Trophite' may be mixed with water, milk, fruit juice or vegetable juice.

PRESCRIPTION SIZE: 'Trophite' is supplied in 4 fl. oz. bottles —enough for 24 days' treatment at the recommended dosage.

TROPHITE*

to increase appetite and growth in below-par children

*T.M. Reg. U.S. Pat. Off.

Smith, Kline & French Laboratories, Philadelphia

Panorama

Biggest headache now plaguing hospitals is not costs and finances but the nursing shortage, an A.H.A. poll shows . . . Don't try to run V.A. hospitals with too little money. Close some of them instead. That's what the V.A. has been told by its chief medical consultants, following Congress' latest appropriations cut . . . Another medical milestone: Mediation (grievance) committees now operate in all states, the District of Columbia, and Hawaii, says the A.M.A. Council on Medical Service

Patients complaining about your fees? Tell them about Judge Don Tidrick of Des Moines, Iowa. He paid a doctor $3 for administering penicillin to his sick daughter—then gave a veterinarian $4 for similarly treating his dog . . A group of Decatur, Ga., doctors have asked city officials to rename the thoroughfare in front of their new clinic building. Seems they don't like the name Cemetery Street . . . Not only the patient is endangered by operating-room blasts: Claiming severe injuries from an exploding anesthetic machine, Dr. James J. Nordland of Evanston, Ill., has filed a $250,000 suit against a local hospital.

Unique emergency-paging system summons doctors from Ohio State's home football games. Developed by Dr. Zeph Hollenbeck of Columbus, it consists of bed sheets suspended from the windows of near-by University Hospital according to a prearranged code . . . There may or may not be a doctor shortage nationally, but there's no question about it in Utah: Only four counties (out of twenty-nine) have enough doctors, says W. H. Tibbals of the Utah State Medical Association . . . Embarrassed by his wife's new book "Are These Our Doctors?" (advertised as a "debunkment of the medical profession"), Dr. Manuel J. Barkins of Scarsdale, N.Y., has written to the A.M.A. in self-defense: "No husband has the right to suppress his wife's independent thinking."

CREMOTHALIDINE®, SULFATHALIDINE® Suspension, is indicated in treatment of both infectious and non-specific diarrheas. CREMOTHALIDINE not only profoundly reduces intestinal bacterial flora, but also helps control other aspects of diarrhea: "cramping in the abdomen subsides (in) about 48 hours . . . blood in the stool disappears, and stool becomes formed and odorless and the number of evacuations are reduced substantially."[1] Supplied in SPASAVER® bottles containing 8 fluidounces.
Sharp & Dohme, Philadelphia 1, Pa.

Sharp & Dohme

1. Streicher, M. H.: Illinois M.J., 88:85, 1945.

Fellows
COMPOUND
Syrup
W/
IRON
QUININE
STRYCHNINE

This is straight talk...

FELLOWS Syrup has yet to be equalled as a *stimulant* and *bitter tonic*.

FELLOWS Syrup is especially valuable for *Geriatric patients* and during convalescence.

FELLOWS Syrup *will*

- *STIMULATE APPETITE*
- *IMPROVE MUSCLE TONE*
- *PRODUCE EUPHORIA ALMOST INSTANTANEOUSLY*
- *ELEVATE THE MOOD WITHOUT AFTER DEPRESSION*

Economically priced...about 2c per dose to patient

Available: 7 and 14 oz. Bottles

Samples? Of course, on your request!

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pharmaceuticals since 1868

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potent

oral

therapy
for
bacterial
infections

Dramcillin

wider
therapeutic
control

greater
convenience

fewer
hypersensitivity
reactions

THE TRUTH ABOUT
FROZEN ORANGE JUICE

Significant Dietary Advantages Of Fresh-Frozen Minute Maid Orange Juice Over Home-Squeezed Orange Juice Shown By Independent Research

RECENT assays[1] emphasize the nutritional superiority of reconstituted Minute Maid Fresh-Frozen Orange Juice over home-squeezed orange juice in three respects:

a. Average levels of natural ascorbic acid were significantly *higher* in Minute Maid;

b. Peel oil content was significantly *lower;*

c. Bacterial counts were dramatically *lower.*

Two reasons for Minute Maid's higher ascorbic acid content are advanced:

First, oranges vary widely in ascorbic acid content.[2] Thus, whole oranges squeezed a few at a time provide a highly erratic source of Vitamin C. Each can of Minute Maid, however, represents the pooling of juice from hundreds of thousands of oranges; thus wide variations in nutrients tend to be eliminated.

Second, because it is frozen, Minute Maid loses none of its ascorbic acid content before reaching the consumer.[3] Whole fruit, however, is subjected to variations in temperature, and care in handling cannot be maintained from tree to table. Laboratory tests have shown an average ascorbic acid loss of 10.7% in whole oranges after 11 days under simulated storage and shipping conditions.

Peel oil, cause of allergic response and poor tolerance, especially in infants,[4] is held to an arbitrary minimum in Minute Maid. Samples of home-squeezed juice expressed by typical housewives showed peel oil contents up to 700% higher.

Bacterial counts were found to be as high as 350,000 per ml. in home-squeezed samples—but were uniformly low in Minute Maid. Technicians ascribe this to the combination of rigid sanitary controls in the Minute Maid process and the low pH and low temperatures at which the juice is kept. High bacterial counts in home-squeezed juice are doubtless due to contamination from the exterior peel which is unknowingly added to the juice during preparation.

In view of the above findings, more and more physicians now specify Minute Maid Fresh-Frozen Orange Juice in lieu of home-squeezed orange juice.

REFERENCES

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(2) U. S. Department of Agriculture Technical Bulletin No. 753, December, 1940.

(3) Roy, W. R., and Russell, H. E., Food Industries, Vol. 20, pp. 1764-1765 (1948).

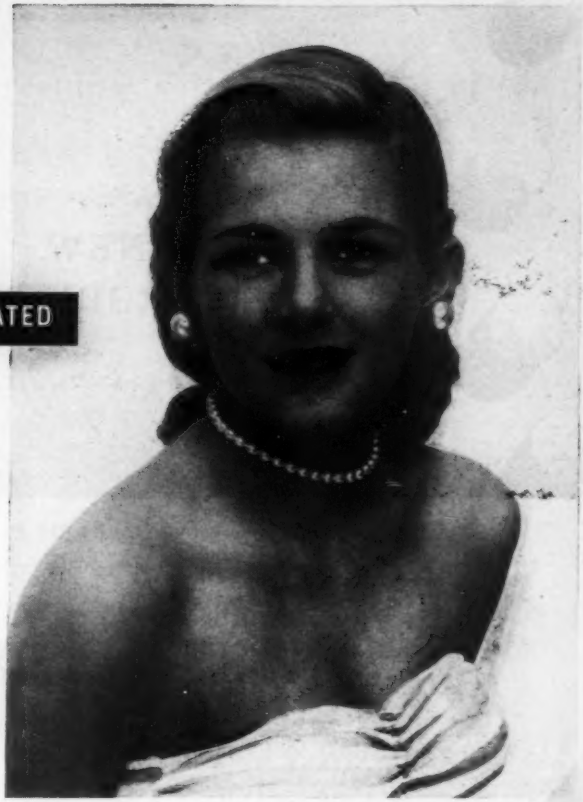
(4) Joslin, C. L., and Bradley, J. E., Journal of Pediatrics, Vol. 39, No. 3, pp. 325-329 (1951).

MINUTE MAID CORPORATION, 488 Madison Ave., New York 22, N. Y.

Wallace R. Roy, Ph.D., Director of Research

SHE'S
BEEN
HYFRECATED

not a
blemish
on her...



Desiccate those unsightly, possibly dangerous, skin growths with the ever-ready, quick and simple-to-use Hyfrecator. 90,000 instruments in daily use.

Please send me your new four-color brochure showing step-by-step technics for the removal of superficial skin growths.

Doctor_____

Address_____

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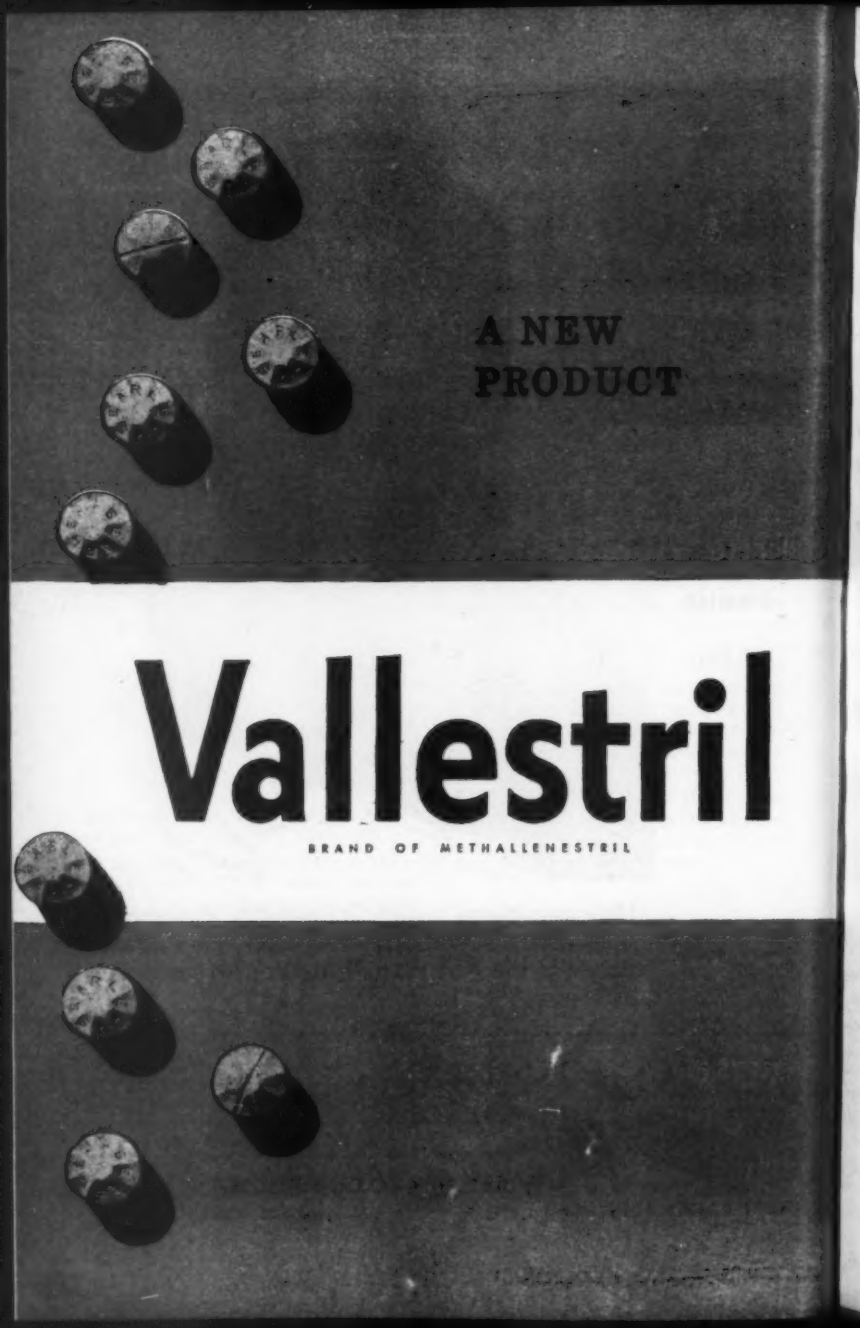
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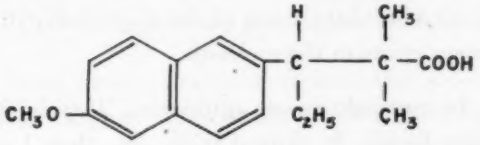
Vallestril
BRAND OF METHALLENESTRIL

Concerning Vallestril*...

Clinical evidence indicates that much estrogen therapy is accompanied by a high incidence of unfortunate side actions such as withdrawal bleeding, nausea and edema . . .

G. D. Searle & Co. presents VALLESTRIL . . .



as an effective estrogenic substance with a *strikingly low incidence* of these undesirable side effects.

Vallestril is available in 3 mg. scored tablets. For treatment of the physiologic or artificial menopause—3 mg. (one tablet) twice daily for two weeks. Then a maintenance dose of one tablet daily for an additional month or longer if symptoms require continued administration.

SEARLE Research in the service of medicine

*Trademark of G. D. Searle & Co.

the new **WELL-TOLERATED**

- *Wide-range* activity gives 'Ilotycin' versatile application in a variety of common infections.
- '*Ilotycin*' *was well tolerated* in clinical trials. No indications of toxicity have so far appeared. No nitrobenzene group exists in the molecule.
- In contrast to some antibiotics, '*Ilotycin*' *does not destroy colon bacilli*. In clinical trials, less than 1 percent of patients had side-effects, and these consisted of a few instances of nausea.
- *In persons allergic to penicillin* and with penicillin-sensi-

Excellent clinical results thus far reported* in pneumococcus pneumonia, staphylococcus bacteremia, pyoderma, follicular tonsillitis, acute nonspecific pharyngitis, severe erysipelas, septic sore throat, peritonsillar abscess, virus pharyngitis, and cellulitis.

Dosage: The average adult dose is four tablets (400 mg.) every [illegible] hours. The dosage will vary with the severity of the infection and the weight of the patient.

Available in 100-mg. tablets in bottles of 36.

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wide-range antibiotic

tive infections, 'Ilotycin' is proving to be the most powerful antibiotic for general systemic use.

- *Against strains resistant to other antibiotics*, especially staphylococci, 'Ilotycin' is proving particularly useful.
- *The cerebrospinal fluid* contains therapeutically active concentrations of 'Ilotycin' when serum levels of the drug are high.
- *'Ilotycin' passes freely into ascitic and pleural fluids.*
- *'Ilotycin' is effective by oral administration.*

Lilly

ILOTYCIN

*References

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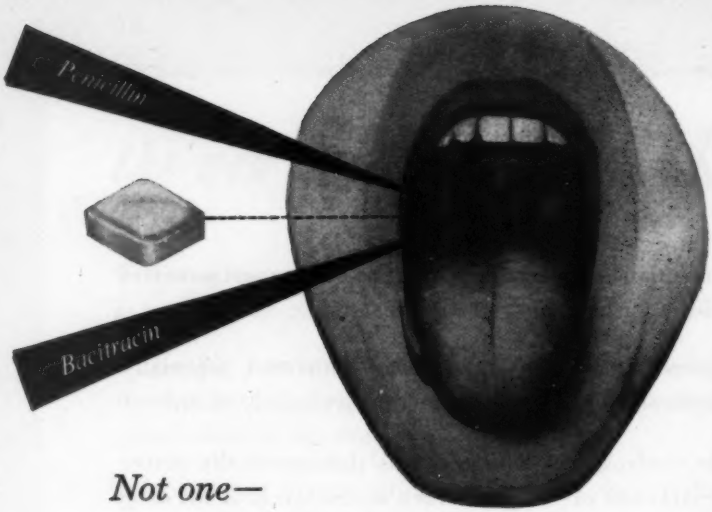
INDIANA, U. S. A.



Not one—

but two—potent antibiotics

PONDETS, the delicious antibiotic troches that look and taste like candy, are active against a wide variety of pathogens commonly found in the mouth and throat.

Penicillin and Bacitracin, each highly effective when employed locally against infections of the mouth and pharynx, are especially effective when combined. Together, they exhibit marked synergism.[1,2]

PONDETS dissolve slowly, supplying an uninterrupted high concentration of each antibiotic to the infected oral and pharyngeal mucosa.

Pondets®

PENICILLIN-BACITRACIN TROCHES

Each PONDET contains 20,000 units crystalline potassium penicillin G and 50 units bacitracin. Vacuum-packed in tins of 48.

Wyeth®

1. Eagle, H., and Fleischman, R.: Proc. Soc. Exper. Biol. & Med. *68*:415 (June) 1948.

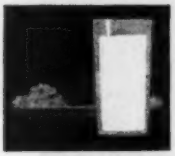
2. Bachman, M.C.: J. Clin. Invest. *28*:864 (Sept.) 1949.

In reducing diets...

DIETENE®
Reducing Supplement

...helps ensure optimum nutrition
...adds *satisfaction* to a low calorie diet

during pregnancy..



DIETENE®
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...improves nutritive intake
...helps avoid excessive weight gain

DIETENE®

Reducing Supplement

...easily mixed with skim milk
...an unusually nutritious and pleasant-tasting adjunct to any low calorie diet

SUPPLIED: In 1- and 5-pound cans, plain or chocolate flavor; available at all leading pharmacies. The 1-pound can retails at $1.55 and lasts for eight days on a 1000-calorie diet.

FREE DIET SERVICE: For your convenience in prescribing a simple and effective dietary regimen, we shall be glad to furnish you with regular or restricted-sodium 1000-calorie reducing diets. The diet sheets contain no advertising matter and are made to look as if they had been typed for the individual patient. These diets ensure excellent patient-cooperation since they permit a wide choice of foods and are easy to follow.

Use the order coupon below for a free supply

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1000-Calorie ☐ Restricted-Sodium 1000-Calorie ☐

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for
convenience
simplicity
efficiency
in parenteral penicillin therapy...

THE BRIST-O-MATIC DISPOSABLE SYRINGE

TRADEMARK

containing

Flo-Cillin* Aqueous

Crystalline Procaine Penicillin G in aqueous suspension

The Brist-O-Matic Disposable Syringe containing free-flowing Flo-Cillin Aqueous provides a measured dose of procaine penicillin G, completely sterile, instantly ready for injection under all circumstances.

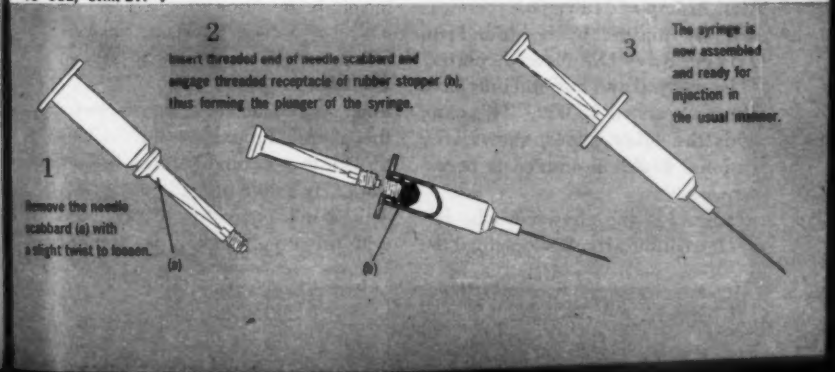
Constructed of polyethylene and completely self-contained, the syringe is contamination-proof and unbreakable. Because Flo-Cillin Aqueous requires no refrigeration, the Brist-O-Matic Syringe unit can always be kept handy for emergency use. Low cost assures its practicality for one-time use, which in turn eliminates any risk of hepatitis transfer.

The BRIST-O-MATIC disposable syringe containing Flo-Cillin Aqueous is supplied as a complete unit in single sterile packages, with a choice of two dosages:

600,000 u. Procaine Penicillin G in 1 cc.
1,000,000 u. Procaine Penicillin G in 1.7 cc.

Bristol
LABORATORIES INC.
SYRACUSE, NEW YORK

TO USE, SIMPLY: ▼



Speaking Frankly

G. P. Apathy

SIRS: I want to compliment you on the very fine article by Roger Menges, entitled "A New Era for the G.P.?" I have reread it three times and feel that it is a thoroughly fair appraisal of the American Academy of General Practice.

Sometimes when a man is actively working in an organization, he can't see the forest for the trees. Although we in the academy had half-suspected that apathy is one of our problems, it took an article like yours to point it out to us.

W. B. Hildebrand, M.D.
Chairman, Board of Directors
Amer. Acad. of General Practice
Menasha, Wis.

A.F.L. Backfire

SIRS: One of your Sidelights quotes a story from the American Federation of Labor News-Reporter about a Mrs. Bishop of Milwaukee who was severely injured by a hit-and-run driver. Says the News-Reporter: "The medical and hospital bills have already reached $5,000." This case, adds the labor paper, shows why national health insurance is necessary.

Since I'm the physician who has been treating Mrs. Bishop since the accident in 1951, I'd like to make some corrections: The patient has so far undergone fifteen major and minor surgical operations. Her hospital bills *alone* have amounted to $5,000. But the patient will verify that after reviewing her financial condition, her doctor decided to render his services without charge.

The A.F.L. publication gave no credit to the medical profession. But would labor render free service in similar circumstances?

M.D., Wisconsin

V. A. Abuse

SIRS: A recent issue of the Journal A.M.A. printed the death notice of a physician who died in a Veterans Administration hospital. Yet, according to the notice, the doctor himself was "owner of a hospital bearing his name"!

Does anyone still doubt that, as your recent article put it, the V.A. hospitals are "free-for-all"?

M.D., Missouri

Health Centers

SIRS: A recent Panorama included this item: "Proposed medical centers for low-income families in New York City's state-aided housing projects won't compete, it's claimed, with private physicians. So Manhat-

new

more potent members of the E

'Eskacillin 500'

palatable liquid penicillin

S.K.F. now offers 'Eskacillin' in a new, higher concentration: *one-half million units* of procaine penicillin G per teaspoonful.

'Eskacillin 500' gives you these advantages:

1. Greater effectiveness in the more severe infections.
2. The convenience of b.i.d. or t.i.d. dosage.
3. Unusual palatability—despite high potency.

'Eskacillin 250'

'Eskacillin 100'

'Eskacillin 50'

the Eskacillin line—for use in the more severe infections:*

'Eskacillin 250-Sulfas'

palatable liquid penicillin plus *sulfonamides*

Each teaspoonful of 'Eskacillin 250-Sulfas' delivers 250,000 units of procaine penicillin G *plus* 0.5 Gm. (0.167 Gm. each) of 3 sulfonamides (sulfadiazine, sulfamerazine, sulfamethazine), thus permitting convenient t.i.d. dosage.

'Eskacillin 250-Sulfas' gives you 3 advantages over penicillin or the sulfonamides alone:

1. **Wide antibacterial spectrum.**
2. **High antibacterial intensity.**
3. **Lessened chance of the development of resistant strains.**

'Eskacillin 100-Sulfas'

Smith, Kline & French Laboratories, Philadelphia

tan doctors have agreed to try them out . . . "

The last sentence gives a false impression; and, as chairman of the Committee on Medical Economics of the Medical Society of the County of New York, I'd like to correct it. A representative of the housing projects presented his proposals at a committee meeting, and we've established a special sub-committee to explore the matter. We're doing this in the spirit of cooperation. But we are not yet committed to approval or disapproval of the plan.

Joseph E. Corr, M.D.
New York, N.Y.

Be Proud!

Sirs: I cannot understand how any true American can object to taking a loyalty oath. Let us be *proud* to declare our allegiance to the best nation on earth.

G. A. Davies, M.D.
Elmer, N.J.

Machine Diagnosis

Sirs: Your Sidelight called "Diagnosis by Machine" is not only ridiculous; it's positively dangerous, since a number of physicians may misunderstand its implications.

In it, you say that a young man with convulsive seizures received psychotherapy from a neurologist "with highly successful results," but that the patient's family, after reading a popular magazine article advising electro-encephalography in all such cases, insisted on this diagnostic procedure. The young man was then given "fruitless hospitalization" for six weeks, with no positive findings.

Concluding that this was a needless waste, you make a plea for the "human"—as opposed to the "machine"—element in diagnosis.

Aren't you aware that the onset of convulsive seizures demands the most detailed investigation? Brain tumors come under many guises; and such procedures as the EEG now enable us to make diagnoses and to initiate therapeutic measures that were unheard of when the doctor with the stethoscope, the benign air, and the cerebral stenosis was all medicine could offer.

The magazine article was completely in order in advising electroencephalography. It would be most interesting to know what the long-term result in this case was.

Crusade as hard as you can against medical abuses, but keep your balance. Medicine *has* made some progress, you know. There are enough problems of importance to be attacked, without reducing ourselves to absurdity.

Philip G. Creese, M.D.
Reading, Mass

While we agree that no diagnostic test should be omitted when indicated, *our intention was to warn against an increasing tendency to rely* solely *on such tests, with no thought of the patient or his pocketbook. Under psychotherapy, the patient had stopped having convulsions. His doctor's diagnosis of*

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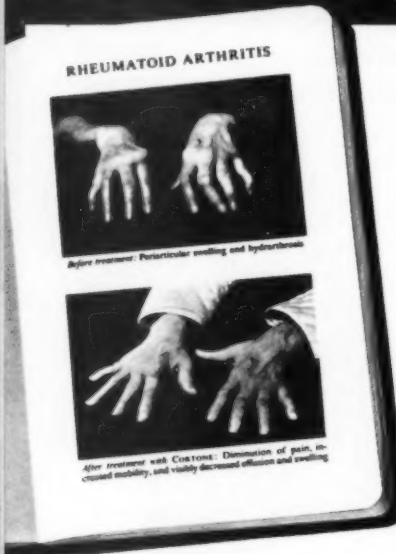

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hysteria was apparently valid. The "human" touch in this case might have spared the patient a long hospital stay—and a bill of $3,100.

Why Not Split?

SIRS: Thank you for publishing Dr. F. E. Bollaert's article, "Why *Not* Split Fees?" It was high time for at least one nationally read journal to publish such views; they're widespread among G.P.'s.

R. N. Pesch, M.D.
Milan, Ill.

SIRS: Dr. Bollaert has hit the nail on the head. The surgeon takes all the traffic can bear, leaving nothing for the family physician. The G.P. is entitled to as much income from a surgical case as the surgeon, since he puts in at least as much work and heartache.

J. Minkin, M.D.
Bronx, N.Y.

SIRS: A fervent handclasp, a pat on the back, and an orchid to Dr. Bollaert for his forthrightness and valor. His words are the first beam of light through the sanctimonious smog spread over our medical world by the "closed corporations" of specialists who have alienated the public by their greed.

Ideally, medicine should be set up like the building trades. When a contractor builds a house, it's his responsibility to employ the excavators, carpenters, plumbers, electricians, and whatever other "specialists" are needed to complete the

structure. But the responsibility rests right where it should: with the contractor.

Let the family physician, too, assume the role of contractor, calling in such specialists as he believes the case needs and paying them himself. Then the patient would get one bill itemizing the services paid for and the amount the family doctor charged for his time and knowledge.

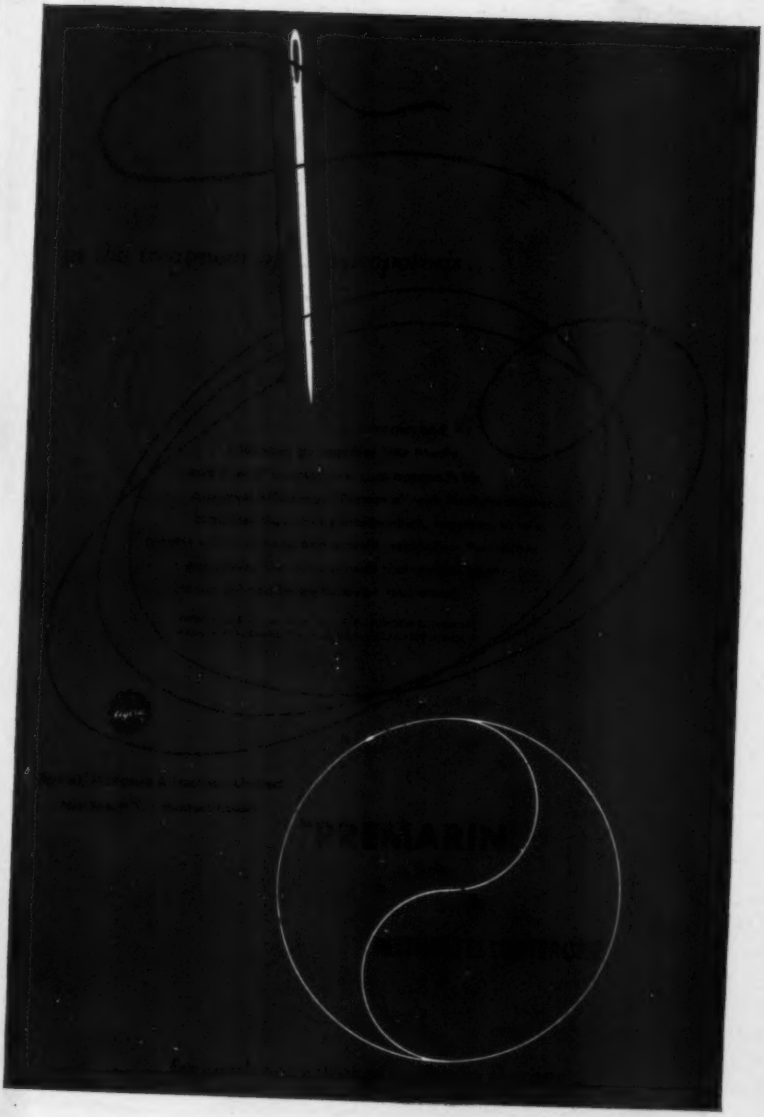
F. W. Hyde Sr., M.D.
Detroit, Mich.

SIRS: Dr. Bollaert's comparison of the general practitioner with the middleman in business is excellent, since both render many courtesy and emergency services. Because of these services the family doctor is justified in his bid for a satisfactory portion of the surgical fee.

There's a great difference between the division of a surgical fee by two doctors who are both active in the case, and the payment of a hidden fee to a doctor who wasn't even present at the operation. Certainly, the ethics code and the Bureau of Internal Revenue ruling are aimed only at the latter.

R. E. Jordan, M.D.
Holton, Kan.

SIRS: Dr. Bollaert's article is the best and most straightforward piece on the subject I have ever read. There is absolutely nothing dishonest about fee division, and the public would be better served if we applied straightforward American business methods to medicine. The claims of the A.C.S. are trumped up



to promote the financial welfare of its members.

E. O. Breckenridge, M.D.
Mason, Tex.

SIRS: A partial solution to the question must come from a more militant general practice section. At present there is a fantastic situation in the A.M.A., where the vast majority have rings in their noses and are meekly abiding by rules that can lead only to state medicine.

M.D., California

SIRS: I have received a number of highly complimentary, encouraging, and militant letters from all over the country about my article. To my amazement, not one has taken issue with me. And it's significant that over 18 per cent of my correspondents identify themselves as members of the American College of Surgeons. This is greater than the ratio of A.C.S. members to the entire physician population!

It seems apparent that many doctors want this matter of financial relations handled by the A.M.A. rather than by one of its self-appointed and self-interested specialty sections. It also becomes apparent that the profession wants action.

As a result, machinery is already in operation to attack and resolve this problem once and for all on a national basis, through the representatives of the majority of the profession.

F. E. Bollaert, M.D.
East Moline, Ill.

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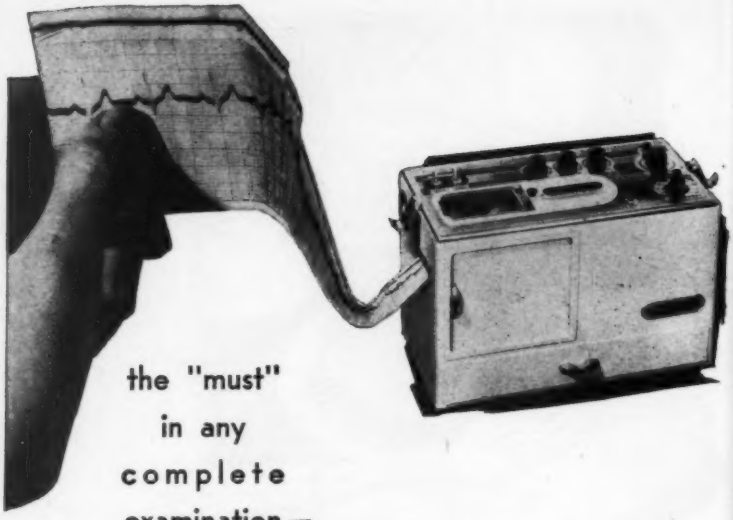

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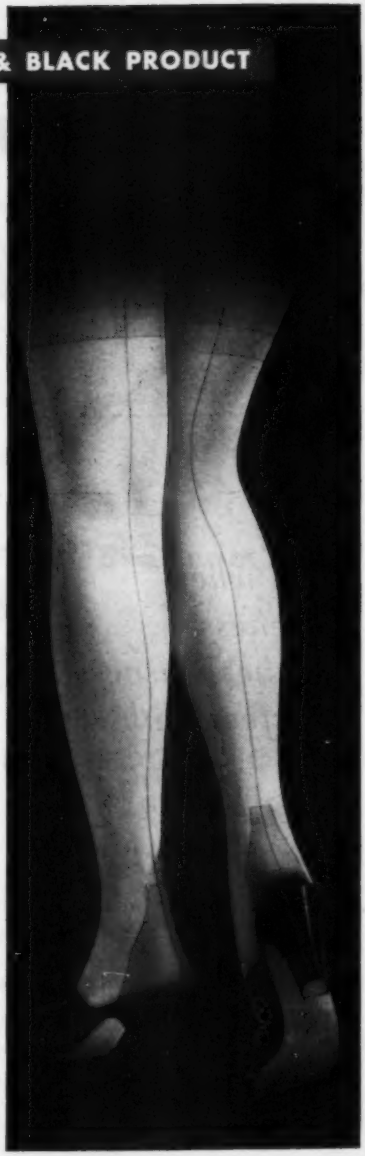

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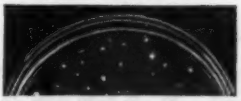

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Sidelights

Reflected Glory

The practicing physician in search of medical immortality can get it in a number of ways. He can, for instance, attach his name to a disease—as Addison and Bright did—or to a well-wearing oath, preferably Hippocratic.

But this kind of activity merely keeps his name on the lips of *other* doctors—at best, a rather limited fame. How can the practitioner win lasting renown among laymen, too?

We were led to these reflections —and to at least one answer—while reading a recent obituary of a well-known physician. The doctor certainly rated a stick or two of type, for he was an outstanding man of medicine. But what was his claim to fame for the average newspaper reader? The death notice *we* read put it right up in the headline:

The late doctor, it seemed, had once "worked on DiMaggio's heel."

The Best Insurance

Can malpractice insurance be detrimental to doctors?

"Yes," is the surprising answer of an acquaintance of ours. He should know what he's talking about; he's the indemnity representative of a big state society's group malpractice plan.

If malpractice insurance weren't available, he says, the number of malpractice suits might actually be cut in half. Why? Because patients would probably hesitate to start expensive court proceedings if they didn't sniff the rich scent of insurance coverage. And also because doctors might be more careful in their day-to-day practice if they had no insurance safeguard.

Does this insurance specialist advocate abolishing malpractice insurance? Of course not. But he does advise physicians to "forget" they have it. "Treat each patient as though nothing protected you against a confiscatory suit except your own conscience and skill," he says. "Then you'll *really* be insuring yourself against mistakes."

Take-Home Pay

Suppose someone asked you point-blank: "How much do you earn?" What figure would first pop into your mind—your gross income, your net income, or your net after taxes?

The gross figure, of course, would be literally correct, since it represents total earnings from practice. In the case of the average independ-

ent physician, this came to almost $25,000 last year.

Yet how thoroughly misleading! Only by spending some $10,000 for overhead can the average M.D. earn this much. If he's at all realistic, therefore, he's likely to say something like this: "My net income runs around $15,000."

An even more realistic figure, however, is *net income after taxes*—a concept that more doctors should think and talk about. In the average case cited, this figure amounts to roughly $12,000, or less than half the first figure mentioned.

Sure, it's pleasanter to contemplate *total* earnings. But it's a lot safer to think in terms of take-home pay. As most wage-earners learned long ago, any other concept invites budget trouble.

Tower of Babel

Physicians are often urged to explain complex medical matters in plain language to patients. It's worth the effort; but, as every doctor knows, it's not easy. And if the physician sometimes fails to make himself clear, maybe he isn't entirely at fault. Even the research scientists—the men who feed the doctor's knowledge—are beginning to have trouble understanding one another.

In fact, science is in danger of building a Tower of Babel. That's what Dr. Vannevar Bush says; and as president of the Carnegie Institution, he ought to know. Dr. Bush charges that modern researchers are divided into overspecialized groups,

each with its own jargon, "unintelligible except to the initiated."

Let's put an end to this confusion, he says; men in the scientific professions should feel morally obligated to express themselves understandably.

That's good advice for anyone who doesn't want to end up talking to himself. It's particularly good for doctors, who—more than anyone else—daily interpret science to laymen.

Get a Horse?

Maybe there's some truth in that double-barreled complaint we're so used to hearing these days. You know how it runs: The old-style family doctor is extinct, and today's physician is a hard-headed materialist rather than a self-sacrificing idealist.

Even if this were true, is the doctor himself entirely to blame for the change in the doctor-patient relationship?

We don't think so. We suggest that the patient, too, is at fault.

More people than used to are seeking medical care for minor ailments these days. That's all to the good. But it means an increased patient-load for the physician, who consequently has less time to spend on really serious cases.

What's more, the intimate doctor-patient relationship of yesteryear depended on a kind of social stability. Patients, for example, used to stay put. Now fewer families remain within reach of the same physician's

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Convalescence is associated with protein loss of serious magnitude, yet little is known of the fundamental nature of the loss.[1] Loss of nitrogen cannot be prevented, however, nitrogen balance can be maintained, wound healing enhanced, and convalescence shortened, by a high protein diet.[2]

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The patient "is better off before his nitrogen stores have been wasted than after. Surgeons have long noted that chronically debilitated patients are poor operative risks."[3] Decubitus ulcers heal quickly in heavily protein-fed patients.[4]

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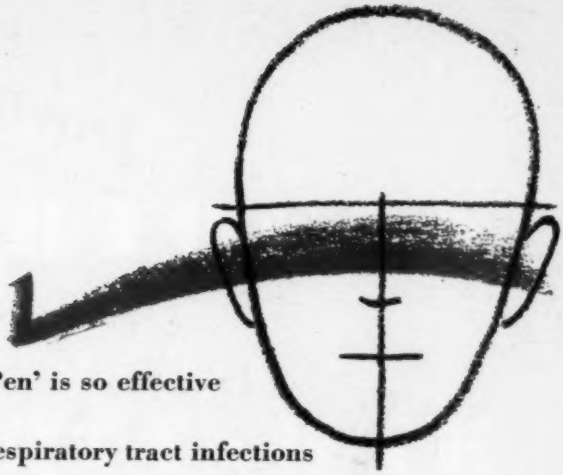
care throughout his career. How can a practitioner maintain a family-doctor relationship with patients who keep moving away?

Particularly in the past decade, the typical practice has included more and more migratory strangers who walk in unannounced and unidentified. It's hardly realistic, we think, to reproach a physician for lacking family-doctor insight into their heredity, temperament, and past history.

Nor can he take for granted their ability and willingness to pay for services rendered. The experiences that a few overtrustful doctors have had with strangers reinforces the tendency in today's doctor to use businesslike methods—especially when extending credit.

Then, too, old patients as well as new ones are increasingly unwilling to accept a diagnosis that isn't supported by X-ray and other procedures. They expect speedy response to emergency calls. They want the latest in often-costly treatment and techniques. So the patient's demands require the doctor to invest in expensive equipment, in a good car, in specialty training and post-graduate study. Yet if his fee reflects these additional overhead expenses, he's accused of materialism.

Nostalgia for the old-time family doctor? Of course; it's natural to yearn for the dear, dead days beyond recall. But we'll take the complaints more seriously when the complainants offer to accept old-style treatment along with the old-style relationship.



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'Par-Pen' contains 5000 units of crystalline potassium penicillin G per cc.; 'Paredrine' Hydrobromide (hydroxyamphetamine hydrobromide, S.K.F.), 1%; in a specially buffered isotonic aqueous solution. Packaged in ½ fl. oz. bottles.

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antispasmin is the most potent of a large series of spasmolytic substances synthesized by Rosenmund and coworkers.[3] Outstandingly effective in the control of spasm associated with peptic ulcers, gastritis, colitis, cardiospasm, dysmenorrhea, and other conditions involving smooth muscle spasm.[2,4,5]

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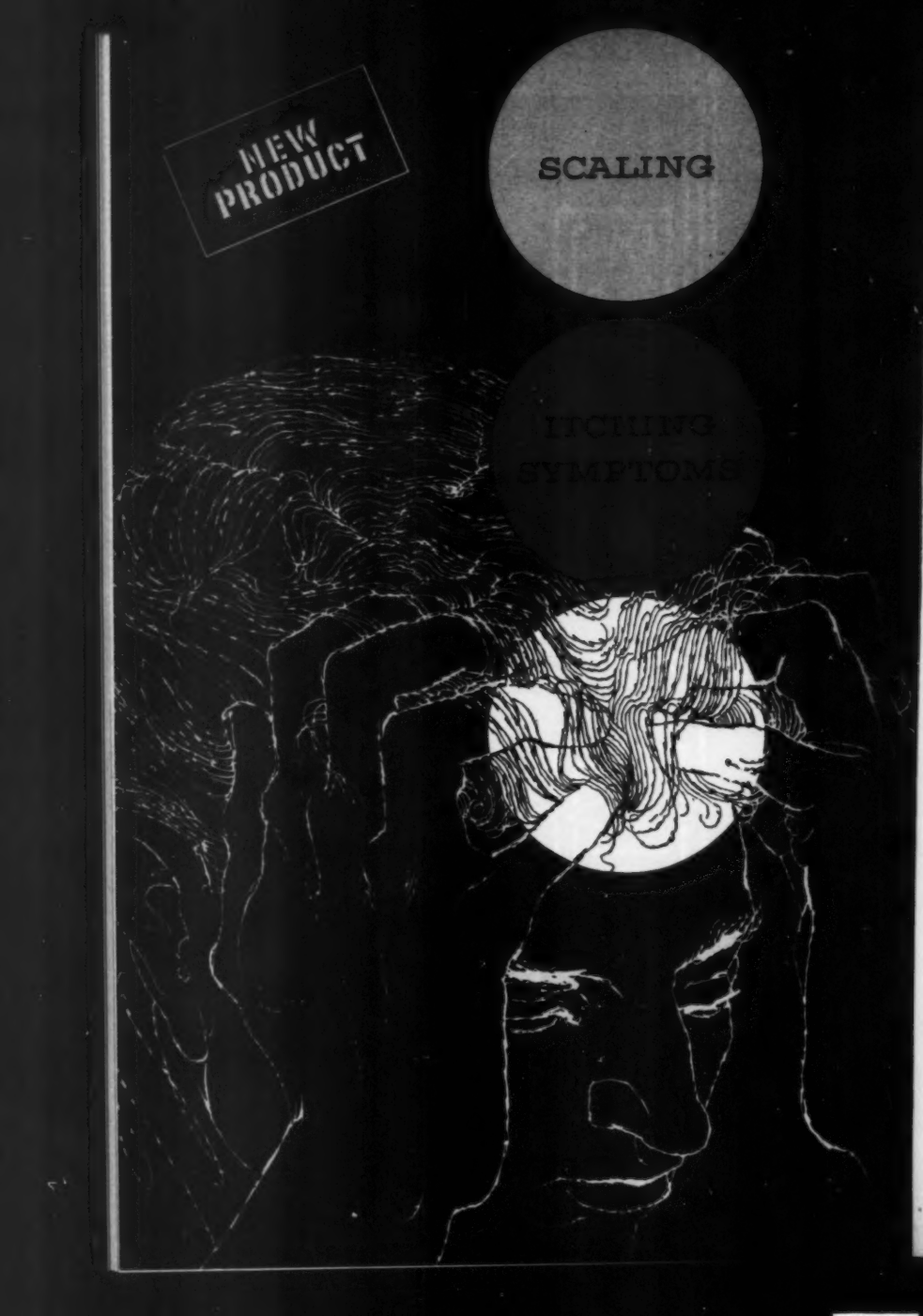
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References:

1. Slinger, W. N., and Hubbard, D. M. (1951), Arch. Dermat. & Syph., 64:41, July.
2. Siepyan, A. H. (1952), Ibid., 65:228, February.
3. Ruch, D. M. (1951), Communication to Abbott Laboratories.

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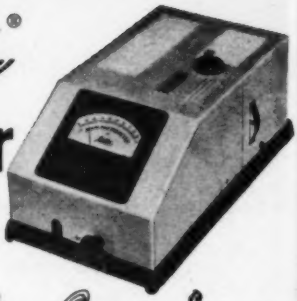

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A NEO-PENIL* CASE HISTORY

(For more information about 'Neo-Penil', see page 198)

Bronchiectasis: Preparation for surgery

Patient: Mr. A.C., age 52, admitted to the hospital November 10. Eleven years' history of bronchitis. In the last 5–6 years he had periodic attacks of severe cough, producing large amounts of purulent, fetid sputum. He had "caught a bad cold" in September and was feeling very poorly, with severe cough, copious expectoration and fever.

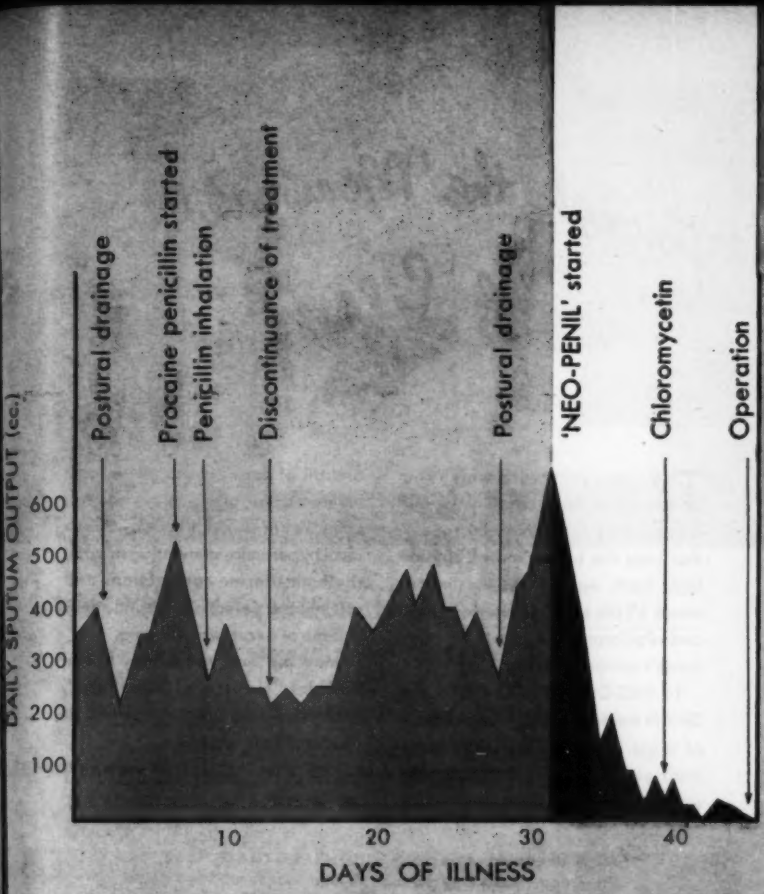
First course of treatment: After sputum cultures were obtained, the patient was treated with procaine penicillin, intramuscularly, 150,000 units daily for 5 days and streptomycin 0.5 Gm. t.i.d. for 4 days. In addition, he was given penicillin inhalations for 6 days. Postural drainage was employed throughout the treatment.

Response: The amount of expectorate decreased but slightly.

On December 4, the patient was transferred to the Department of Thoracic Surgery of a larger hospital, for operation. Bronchoscopic examination revealed marked bronchiectasis in all segments of the left lower lobe. The upper lobe, including the lingula, showed no abnormality. The sputum volume was now 600 cc. per day.

Second course of treatment: In the hope of reducing the sputum volume before operation, the patient was given 'Neo-Penil', intramuscularly, 1 million units the first day, 1 million units b.i.d. the second day, and 1 million units t.i.d. thereafter. Postural drainage was reinstituted.

Response: After 6 days, sputum volume was reduced from 600 cc. to 50 cc. per day. At this time sputum culture revealed penicillin-resistant bacteria and chloromycetin was given, 0.5 Gm. every 6 hours for 5 days. The sputum volume was further reduced, and it was felt safe to operate.



'Neo-Penil' is a new, long-acting derivative of penicillin, which concentrates in the lung and sputum (see page 198). It is available at retail pharmacies in single-dose, silicone-treated vials of 500,000 units.

Smith, Kline & French Laboratories, Philadelphia

*T.M. Reg. U.S. Pat. Off. for penethamate hydriodide, S.K.F. (penicillin G diethylaminoethyl ester hydriodide) Patent Applied For

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Through the Menstrual Years of Life . . .

THE frequency with which the menstrual life of so many women is marred by functional aberrations that pass the borderline of physiologic limits, emphasizes the importance of an effective uterine tonic and regulator in the practicing physician's armamentarium.

In ERGOAPIOL (Smith) with SAVIN the action of all the alkaloids of ergot (prepared by hydro-alcoholic extraction) is synergistically enhanced by the presence of apiol and oil of savin. Its sustained tonic action on the uterus provides welcome relief by helping to induce local hyperemia, stimulating smooth, rhythmic uterine contractions and serving as a potent hemostatic agent to control excessive bleeding.

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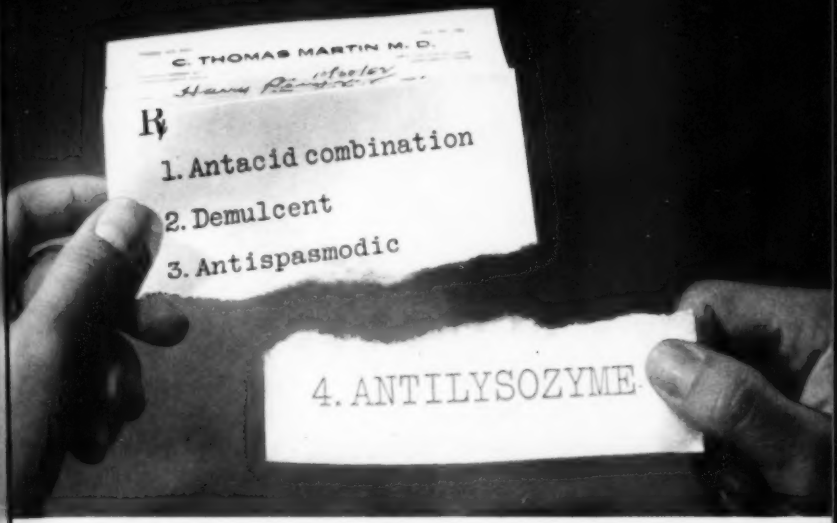

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3. **A SUPERIOR ANTISPASMODIC** (BENTYL Hydrochloride) which provides direct smooth muscle and parasympathetic depressant qualities without "belladonna backfire."
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DOSAGE: 2 Kolantyl tablets or 2 to 4 teaspoonfuls of Kolantyl Gel every 3 hours as needed for relief.

1. Hufford, A. R., Rev. of Gastroenterology, 18:588, 1951
2. Miller, B. N., J. So. Carolina M. A., 48:1, 1952

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WITH PHENOBARBITAL . . . . . 15 MG.

DOSAGE: *Adults*—2 capsules or 2 teaspoonfuls syrup 3 times daily, before or after meals. If necessary repeat dose at bedtime.
In Infant Colic—½ to 1 teaspoonful syrup 3 times daily before feeding.

Editorial

Outmoded Ethics

• In explaining medical ethics to the public, the A.M.A. often relies on the descriptive phrase, "The Code Your Doctor Lives By."

Yet the average doctor *doesn't* live by the code—at least not to the letter. He can't. Too many passages are vague, contradictory, or years behind medical practice.

The code underwent a major revision in 1949 (and, before that, in 1880). Medicine changes greatly in sixty-nine years. It even changes in three—as witness this sampling of provisions in the present code that no longer make complete sense:

¶ *"Poverty of a patient . . . should command the gratuitous services of a physician . . ."* But what about the growing number of indigent care plans? Sponsored by many cities and some states, they pay the doctors reduced-rate fees. Obviously "gratuitous services" aren't expected here. Yet our ethics code still implies that they are.

¶ *"Among unethical practices are . . . furnishing or inspiring newspaper or magazine comments concerning cases in which the physician . . . is concerned . . ."* This sweeping ban has been rendered obsolete by the press cooperation codes sponsored by local medical societies. These clearly permit doctors to be quoted in print under specified conditions.

¶ *"A physician should not . . . prescribe for another physician's patient during any given illness . . . until the other physician . . . has been formally dismissed . . ."* The general principle is laudable, the specific requirement wildly impractical. How can a doctor know, for example, whether his hypertensive patient has "formally dismissed" all previous physicians who have prescribed for his condition? What, indeed, does "formally dismissed" mean?

¶ *"An ethical physician does not engage in barter or trade in the appliances, devices, or remedies prescribed for patients . . ."* This unfairly stigmatizes small-town doctors who, in the absence of 24-hour drugstore service, must dispense some of the medicines their patients need. It unfairly stigmatizes other physicians who provide an occasional patient with eyeglasses, say, at cost.

¶ *"All voluntarily associated activities with cultists are unethical . . ."* Yet the A.M.A. Judicial Council has approved one-shot consultations with osteopaths; also, the shar-

ing of facilities with them in small, outlying hospitals.

* * *

"Does it really matter," some may ask, "if medical ethics are a bit out of date?"

We think it does. If even a few provisions are unworkable, most doctors will pay less heed to the many other provisions that can—and should—be followed to the letter.

Our code needs much more frequent revamping—not just by ethics experts, but also by specialists in semantics.

—H. SHERIDAN BAKETEL, M.D.

What's in the Magnuson Report ?

More teamwork in medicine seen as dominant theme of commission recommendations

● President Truman will get at least one Christmas present this year that isn't exactly what he had in mind.

It's the report of the President's Commission on Health Needs, due before December 29. From all advance indications, it fails to recommend a project close to Harry's heart: national compulsory health insurance.

Will doctors find the report any more to their liking? Chances are that they will. "Build on what we have" appears to be its motif—build on private medicine, build on voluntary plans, build on existing methods of government support.

And if some of the building ideas prove controversial, doctors will still find them worth serious thought. For the ideas stem from a year-long review of all pertinent facts; from the private testimony of nearly 500 medical and lay experts; and from nearly 3 million words of commission discussion. Not for years have medical care problems had such a talking-out.

"Our report probably won't suit anybody in its entirety," says Dr. Paul Magnuson, commission chairman. "Too many people are looking for little green pills that will cure all their troubles—and there ain't none. Too many other people don't want any interference with the cultivation of their own private gardens. Medical care problems are too pressing for us to tolerate either point of view.

"We have not come up with any shining Utopias; nor have we been able to do a completely comprehensive job in the brief year alloted to us. But I'm confident that nearly everyone will find something of value in the commission's proposals."

What *are* the commission's proposals?

Though not yet made public, they are clearly foreshadowed by preliminary findings. These constitute the raw material with which the commission has recently worked. They'll be refined and polished in the final report; but only in isolated instances are they likely to be reversed.

It's upon these preliminary findings that this article is based. Compressed into a single paragraph, they might be summed up thus:

We need more teamwork in med-

By R. Cragin Lewis

icine—more teamwork between specialists and general men (through expanded hospital staffs and new medical groups); more teamwork between big medical centers and outlying hospitals (through regional extension of special services); more teamwork between all levels of government and all kinds of voluntary medicine (through stronger support for health facilities, medical schools, and low-income patients).

This sort of teamwork, the commission believes, can't be superimposed from above; it has to be built from the bottom up. "The individual himself is going to have to take the initiative," says Commissioner Lowell Reed. "This is not something that can be delivered to him."

Everybody's Business

But while stimulating individual interest, the commission also recognizes a group interest. "Health is everybody's business," as Commissioner Clarence Poe puts it. "And when a man gives a low priority to health, the rest of society can't just shrug and say, 'That's rugged individualism.' "

In other words, *laissez-faire* medicine is not recommended.

What *is* recommended is that more money be spent on health—by individuals, by voluntary organizations, by government. "Just because we now spend 3 to 4 per cent of national income for health," asserts Commissioner Walter Reuther, "that shouldn't limit us. That horizon can be broadened." And other commission members echo the testimony of Dr. Alan Gregg: In terms of what medicine has to offer today, "we are all just pikers" in what we spend for health.

Rx: Integration

The commission's favorite word—and you'll be hearing more of it—is *integration*. Its discussions have focused sharply on (1) local integration, (2) regional integration, and (3) government integration—plus (4) health insurance, which requires integration with everything else.

What, exactly, does "integration" mean?

The answers emerge clearly from preliminary findings, offering us the best possible line on the commission's report. So let's move in for a close-up of these integration proposals; let's see what they might mean for doctors everywhere:

1. LOCAL INTEGRATION. The curse of small-town practice, the commission was told, is "professional isolation." The case of a North Carolina G.P. was cited: He'd had four years of hospital training, was doing well in a town of 300. But he found himself cut off from specialists, from health services, from professional education. He was stagnating—and he knew it.

Such isolation also exists in our largest cities. "In the very shadow of our great medical centers," said one panel member, "some of the worst general practice is found . . . Many an urban G.P. works alone,

without nursing or other assistance, dissociated almost completely from his colleagues, and without worthwhile hospital privileges . . ."

This last-named item is regarded as one root of the trouble. From 35 to 55 per cent of doctors in some cities lack hospital connections, the commission was informed; and in the absence of higher-fee hospital cases,

Key Facts About the Magnuson Commission

NAME: The President's Commission on the Health Needs of the Nation.

ORIGIN: Established by executive order of President Truman in December, 1951.

ASSIGNMENT: "To make a critical study of our total health requirements . . . and to recommend courses of action to meet these needs."

MEMBERS: Fifteen people chosen by Chairman Paul B. Magnuson —"the most independent thinkers I knew of in the medical, educational, and consumer fields"—including ¶ *Five medical men:* Dr. Magnuson, orthopedic surgeon from Chicago; Dean A. Clark, director of Massachusetts General Hospital; Donald Clark, general practitioner from Peterborough, N. H.; Evarts A. Graham, St. Louis surgeon; Russel V. Lee, group practitioner from Palo Alto, Calif. ¶ *Five educators:* Lester W. Burket, dental dean at the University of Pennsylvania; Joseph C. Hinsey, medical dean at Cornell; Charles S. Johnson, president of Fisk University, Nashville, Tenn.; Lowell J. Reed, vice president of Johns Hopkins; Marion W. Sheahan, nurse educator. ¶ *Five consumer representatives:* Chester I. Barnard, president of the Rockefeller Foundation; Albert J. Hayes, head of the A.F.L. machinists' union; Elizabeth S. Magee, secretary of the National Consumers League; Walter P. Reuther, president of the C.I.O. auto workers; Clarence Poe, editor, The Progressive Farmer.

METHODS: (1) Review of all pertinent health and economic studies. (2) Collection of informed opinions at regional hearings in eight cities. (3) Discussion of major health problems with invited experts at thirty panel sessions in Washington. (4) Summarizing of panel discussions in a series of written digests. (5) Analysis of the foregoing at closed commission meetings. (6) Publication of commission findings and recommendations in a five-volume report.

such doctors often take on more office work than they can handle. They're forced "by economic circumstance" to do it, the panel concluded—and the result is rushed, impersonal care.*

The proposed solution? First, provide the G.P. with more professional help. A multiple-disease screening clinic in Richmond, Va., was cited as an example; it saved the doctors' time, brought patients to them. Another example: a visiting nurse service in San Francisco. "We have the finest cooperation imaginable from these nurses," a local G.P. told the commission. "They save us many, many home calls . . . The idea should be fostered."

Second, bring the G.P. into the hospital. "He has got to have hospital beds or he cannot practice good medicine," one panel member said. Besides, another pointed out, a staff connection helps the G.P. keep up to date professionally. And besides that, it enables him to "earn at least what a bricklayer would earn for the same hours expended."

Third, find out what the G.P. can do in specialized fields like surgery. The panel consensus: "Everyone agrees that he should *not* do certain things—brain surgery and chest surgery, for example. No one agrees what he *should* do. This will be a lot easier to decide when he's working as part of a team.

"Actually, when he's made part of a team, the G.P. often ends up working as an internist. Perhaps in future he should be trained as such. And perhaps today's internists are tomorrow's family doctors."

Split Over Groups

What about integrating specialists, along with general men? Group practice is viewed as the best bet here—but with some interesting dissents. Note this panel testimony (condensed):

¶ "I am satisfied that a group can handle a complex medical problem more economically than solo practitioners can. I am *not* satisfied that a group can handle a simple illness any more economically."

¶ "Medical societies cannot encourage groups, because they compete with the solo practitioners who comprise most of the societies' membership."

¶ "Physicians are, on the whole, suspicious of group practice. Its development can come about only through education and demonstration."

What sort of demonstration? Well, take Minnesota. Its medical care standards rank with the best in the land, the commission was told. And why? Primarily, because of the large number of medical groups there. The resulting competition "has jacked up standards all along the line."

It took the Mayo influence to get groups started in [MORE ON 182]

*In a recent argument between internists and general practitioners, the internists won their point by saying: "Well, at least we get *our* patients undressed." Commented the G.P. who reported this to the commission: "That hurt—because of the number of G.P.'s who *don't* [take time to] get their patients undressed."

Your Economic Weather Vane

A report on the

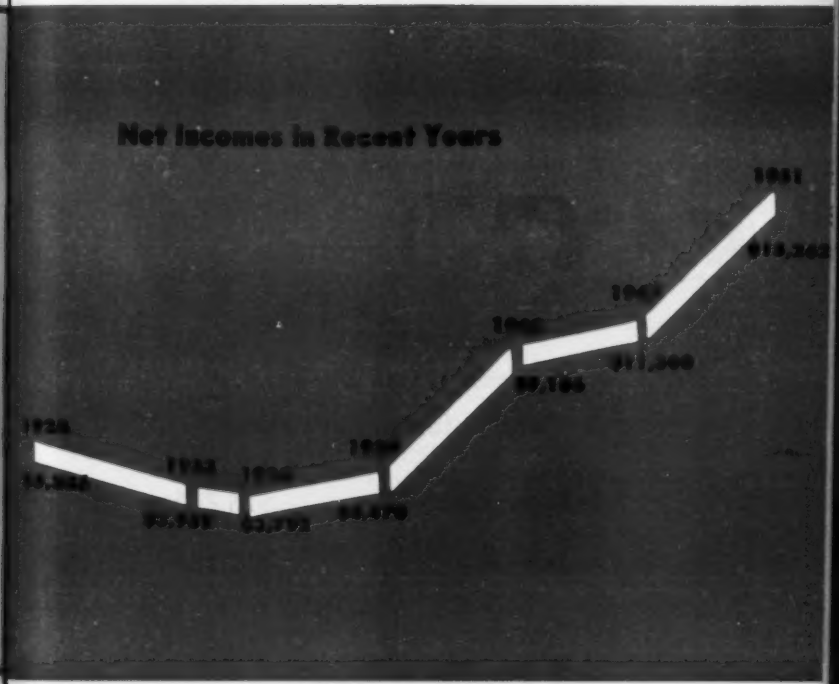
Seventh MEDICAL ECONOMICS Survey

The facts in the following pages stem from the replies of about 5,000 practicing physicians to a questionnaire sent them by this magazine in April, 1952. These doctors constitute a representative cross-section of the profession; the information they supplied covers many phases of the economics of private medical practice in the U.S. In previous installments of survey data, we discussed such topics as the "average" physician, fees, and general practice. This month we take up doctors' incomes. In the months ahead, we'll analyze such matters as expenses, collections, working hours, patient load, and assistants. For a detailed account of how the Seventh MEDICAL ECONOMICS Survey was conducted, see page 121.

Physicians' Incomes

Average Gross Income	**$24,770**
Median Gross Income	$21,000
Average Net Income	**$15,262**
Median Net Income	$13,150

Unless otherwise qualified, the income figures in this article are 1951 averages for independent physicians. Independent physicians are considered to be those in private practice who derive more than half their net income from fees for service.


Net Incomes in Recent Years
1951
1944
1936
1933
1926

Your Economic Weather Vane

(Incomes—*Cont.*)

Incomes by Field of Practice

	Gross	Net
General practitioners	$23,766	$14,098
Partial specialists	24,404	15,119
Full specialists	26,495	17,112

Net Incomes of Independent and Salaried Physicians

Independent	$15,262
Salaried	10,314

Incomes of Group and Solo Physicians

	Gross	Net
Group or partnership	$24,023	$16,591
Solo	23,803	14,665

The solo category consists of independent doctors only; the group-partnership category consists of both salaried and independent doctors.

Incomes by Sex

	Gross	Net
Men	$25,014	$15,327
Women	16,243	9,006

Your Economic Weather Vane

(Incomes—*Cont.*)

Generally speaking, the farther west a doctor practices, the higher his potential income. Thus, physicians in New England and the Middle East have the lowest incomes in the country, while physicians in the Far West have the highest. This has apparently held true for at least a decade.

Incomes in the Various Regions

	Gross	Net
New England	$18,737	$12,158
Middle East	20,050	12,938
Southeast	26,505	16,048
Southwest	25,843	15,947
Central	26,300	16,928
Northwest	27,563	16,431
Far West	32,219	17,900


WEST


WASH.
MONT.
N.D.
MINN.
ORE.
IDAHO
S.D.
WIS.
MICH.
N.Y.
Northwest
WYO.
Central
Middle
East
Far West
NEV.
IOWA
NEB.
ILL.
IND.
OHIO
PA.
UTAH
COL.
W. VA.
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CALIF.
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ARIZ.
N.M.
OKLA.
ARK.
Southeast
S.C.
Southwest
MISS.
ALA.
GA.
TEX.
LA.
FLA.

Your Economic Weather Vane
(Incomes—*Cont.*)

Median Net Incomes In Selected Cities

Baltimore	$11,100
Boston	10,500
Chicago	14,000
Cleveland	15,600
Detroit	13,500
Los Angeles	12,500
New York City	10,000
Philadelphia	10,400
St. Louis	15,000
Washington	12,794

Median Net Incomes In Selected States

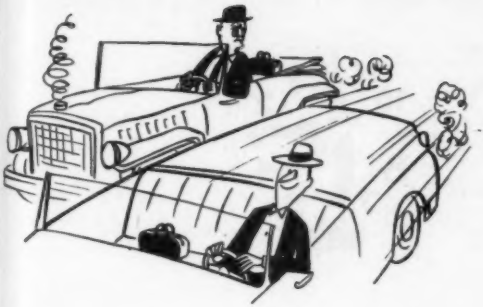
California	$14,600
Colorado	11,460
Connecticut	12,880
Florida	14,000
Georgia	12,759
Illinois	15,100
Indiana	14,207
Iowa	13,356
Kansas	15,430
Kentucky	15,649
Maryland	11,246
Massachusetts	10,564
Michigan	16,276
Minnesota	14,000
Missouri	14,029
Nebraska	14,000
New Jersey	10,850
New York	10,819
North Carolina	14,933
Ohio	14,766
Pennsylvania	11,508
Texas	14,147
Virginia	14,270
Washington	16,200
Wisconsin	13,000
All U.S.	13,150

Your Economic Weather Vane
(Incomes—*Cont.*)

From 1947 through 1951, the most impressive income gains were made by physicians in towns of under 50,000; their net incomes went up, on the average, more than 40 per cent. This is more than double the rate of increase registered by medical men in cities of 500,000-1,000,000—the classification where the smallest gains occurred.

Incomes by Community Size

	Gross	Net
Under 5,000	$24,121	$13,870
5,000-49,999	26,531	16,308
50,000-499,999	26,337	16,610
500,000-999,999	24,027	15,265
1,000,000 and over	20,979	13,104



Apparently, young doctors have benefited the most, and old doctors the least, from the rise in physicians' incomes from 1947 through 1951. The average net income of physicians with under ten years in practice is 53 per cent higher than it was four years ago. During the same period, the figure for men with thirty or more years in practice has gone up only 16 per cent.

Incomes by Years in Practice

	Gross	Net
Under 10	$22,964	$14,312
10-19	28,252	16,890
20-29	25,728	16,372
30 and over	19,670	11,999

Your Economic Weather Vane

(Incomes—*Cont.*)

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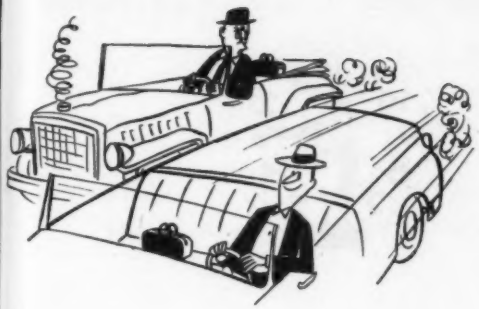

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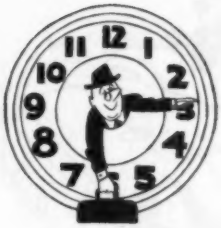
Your Economic Weather Vane

(Incomes—*Cont.*)



Hourly Incomes

	Gross	Net
All fields of practice	$ 8.54	$5.25
General practice	7.71	4.58
Part-time specialties	8.47	5.25
Full-time specialties:		
Dermatology	12.10	7.80
Ear, nose, throat	10.40	6.95
Eye, ear, nose, throat	12.41	6.77
Internal medicine	7.71	4.69
Obstetrics/gynecology	10.15	6.50
Ophthalmology	12.18	7.59
Orthopedics	9.84	6.60
Pediatrics	7.22	4.54
Psychiatry/neuropsychiatry	7.99	5.98
Roentgenology/radiology	13.10	7.52
Surgery	11.08	7.08
Urology	10.10	6.14

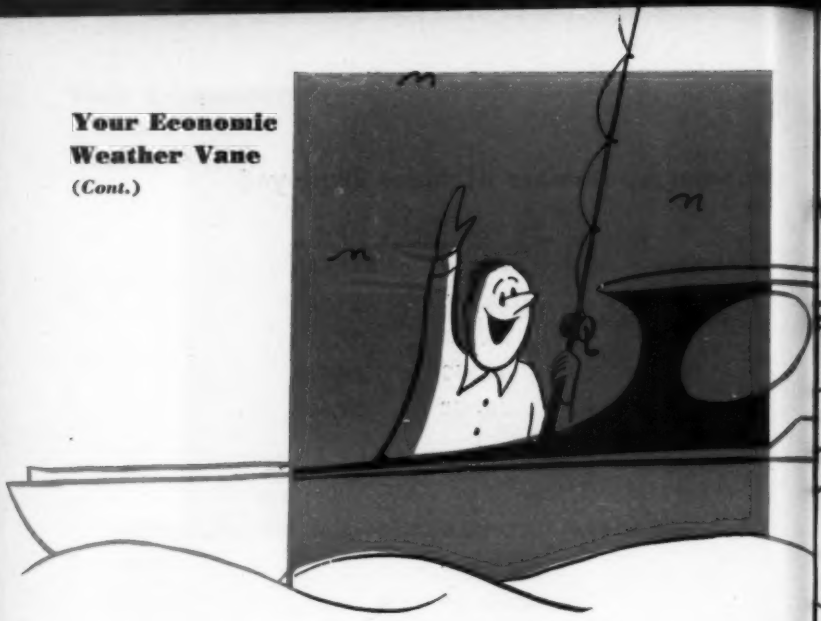
Incomes by Number of Aides Employed

	Gross	Net
None	$22,656	$11,460
One	22,924	14,536
Two	33,312	19,813
Three	44,563	24,673
Four or more	55,833	27,407

Net Incomes by Number of Patients Seen Daily

Under 10	$ 8,491
10-19	10,738
20-29	14,250
30-39	17,173
40-49	21,243
50 or more	30,982

Your Economic Weather Vane
(Cont.)



The High-Income Doctor

• Reporting physicians' incomes in the form of averages obscures the fact that some doctors earn a lot more—and some a lot less—than those averages. To cite just one example of this wide variance:

The top 10 per cent (income-wise) of independent M.D.'s take in about 25 per cent of the total gross income received by *all* such M.D.'s. The bottom 10 per cent get only about 3 per cent.

This article deals primarily with physicians in the high-income bracket. About 7 per cent of the country's independent doctors were in this bracket in 1951, with net earnings from practice of $30,000 or more. In sharp contrast were the 7 per cent at

the low end of the scale, who netted under $5,000.

Although the high-income practitioner naturally has much heavier operating expenses than his low-income colleague, such expenses consume a lower percentage of his gross. The average physician who grosses around $30,000 a year, for example, reports expenses amounting to 38 per cent of that gross—or about $11,500. The $5,000-a-year man, on the other hand, spends 52 per cent of his gross—or about $2,600—on expenses.

Nor do the two men divide their expense dollar in the same way. Biggest expense items for the high-income physician are salaries ($3,047) and drugs and supplies ($2,391); for the low-income man, they're rent ($598) and automobile upkeep ($404). The $30,000-a-year physician spends ten times as much as the $5,000-a-year man on salaries, six times as much on drugs and supplies, four times as much on instruments and equipment, and twice as much on rent and auto upkeep.

It's easy to see why the top-bracket M.D. spends so much on salaries. He's likely to have at least two full-time aides, while the bottom-bracket physician usually gets along with either one aide or, more often, none. The average weekly salary for assistants employed by high-income men is $80; for those employed by low-income doctors, it's $37.

The doctor who nets $30,000 or more sees an average of forty-four patients a day. This is three times the average number seen by the physician netting under $5,000.

It's not surprising, in view of this, that the high-earner puts in a long work-week of sixty-four hours, as against the forty-seven-hour week of the low-earner.

Of course, there's more to realizing a high income than seeing a lot of patients, working long hours, and hiring extra personnel. For instance:

The average physician netting $30,000 or more charges higher fees than the one who nets under $5,000 (27 per cent more for an office call, for example). He collects a slightly higher percentage of his bills (86 as against 82 per cent). And he receives about three times as much in payments from Blue Shield and other health plans.

These figures tell something about the way the high-income doctor conducts his practice. But still largely unanswered is the question of *how* he gets into the upper bracket.

Part of the answer may lie in the fact that he's had much more training and experience than the man at the other extreme. By and large, high-income men have had specialty training and have been practicing at least ten years. The under-$5,000 group, on the other hand, is made up largely of G.P.'s with less than ten years' practice.

Another factor that may bear on a doctor's income is the economic status of his patients. The survey shows, at any rate, that physicians' incomes are highest in the Far West—the same region where, according to the Department of Commerce, over-all per-capita income is highest.

A doctor's income is often influenced, too, by the number of colleagues who compete with him in his community. Where competitors are few, he naturally tends to see more patients, and he may also charge more for his services.

In fact, there are times when the doctor-shortage factor outweighs the factor of patients' incomes. For example: In some Southern states where the per-capita income level is low, physicians' incomes are high. Conversely, in some metropolitan areas where per-capita incomes are high, doctors' incomes are low. The Southern states, of course, have relatively few doctors, while the big cities have them in abundance.

Physicians' Income Ladder

(Cumulative percentages of independent M.D.'s at various net-income levels, 1951)

$40,000 or more	2.7%
35,000 or more	4.1
30,000 or more	7.0
25,000 or more	13.1
22,500 or more	17.1
20,000 or more	23.3
17,500 or more	30.4
15,000 or more	41.9
12,500 or more	53.9
10,000 or more	69.0
7,500 or more	81.6
5,000 or more	92.7
2,500 or more	97.7

A Medical Center for Every Community

That's what a new national group aims at. Here's the story—with reservations

● Wherever the practicing physician looks nowadays, there's somebody all set to organize medical care on his behalf.

The danger of government-organized medicine may be subsiding; but at the local level, fresh challenges to private practice are on the upswing. Most of these take the form of lay-sponsored pressure for large-scale group-practice health center schemes, supported by voluntary prepay plans.

Already a good many labor unions have muscled into the act. Now big business, too, is trying to buy a piece of the show. The latest, and potentially the biggest such program is that of the business-supported American Federation of Medical Centers whose national program was announced just before Election Day during a luncheon press conference held at Manhattan's Waldorf-Astoria Hotel.

The A.F.M.C., a non-profit organization, hasn't built or run any local medical centers—and doesn't intend to. Its function is to stir up local interest, then do necessary surveying, planning, and educational work for communities that want health centers. Its goal: "for the first time to solve the whole problem of medical care on a community basis."

In every city, depending on its size, A.F.M.C. officials want to see one or more such medical centers established. Each, they say, will be set up "like a functionally-designed industrial plant". It will provide all the known "bests" in medical practice through group organization. And it will place equal emphasis on preventive and curative medicine.

Thus the subscribers will, medically speaking, get the works. They'll pick their family physician from the group; they'll go to the center for dental, specialist, diagnostic, and hospital care. And the premium cost for these comprehensive benefits, the A.F.M.C. figures, will be under $100 a year for each subscriber. This sum, it says, is about the present per capita expenditure in the U.S. for "partial" health care.

The A.F.M.C. idea isn't a new one. In fact, as its founder, Dr. Edgar H. Norris, Detroit surgeon and medical educator, points out, the plan stems directly from the 20-

By James C. Fuller

year-old report of the Committee on the Costs of Medical Care. In 1932, this committee recommended that "medical services, both preventive and therapeutic, should be furnished largely by organized groups of physicians, dentists, nurses, pharmacists, and other associated personnel. Such groups should be organized, preferably around a hospital, for rendering complete home, office, and hospital care."

In addition, said the committee, "the costs of medical care [should] be placed on a group payment basis" —by insurance, taxation, or both.

In so many words, this is what the A.F.M.C. wants, too.

If these recommendations had been carried out, says Dr. Norris, medicine's biggest problems might have been solved by now. But no national organization was set up to do the job. Hence the new A.F.M.C., established after a six-year study of medical care costs and distribution by Dr. Norris, former dean of Wayne University College of Medicine.

As a working example of what it is projecting for the country, the A.F.M.C. has its eye on the Health Insurance Plan of Greater New York, which Dr. Norris regards as "the most practical, forward-looking plan now in operation." However, A.F.M.C. would adapt H.I.P. principles to the conditions and needs of each community.

The sponsors of A.F.M.C. are at present mainly businessmen. Among the directors are Wendell W. Anderson, president of the Bundy Tubing Co., Detroit, chairman; Frank Surface, assistant to the president, Standard Oil Co. of New Jersey; plus a New York lawyer and a Detroit real estate man. Their answers to the question "Why is this program necessary?" are [MORE ON 174]

Lay and medical leaders of the American Federation of Medical Centers mull over plans for setting up a network of medical centers financed on a prepayment basis. Left to right: Wendell W. Anderson, chairman of A.F.M.C.; Dr. Edgar H. Norris, its founder; Dr. Lawrence Pratt; and Frank Surface.

Eleven Weeks at a G.P.'s Elbow

A picture report on how a novice learns that medical practice is patients plus patience

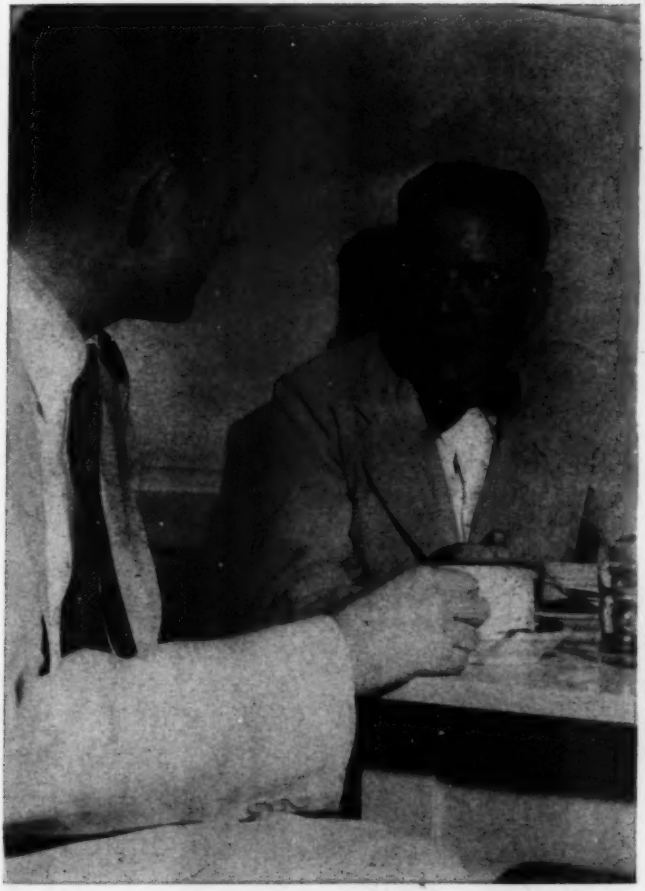
EXTRA HELPING HANDS when needed and the satisfaction of imparting one's skills to an appreciative beginner—that's the reward of seventy G.P.'s now acting as preceptors to seniors of the University of Texas School of Medicine. Under sponsorship of the Texas Academy of General Practice, these men give students a taste of actual practice. Each G.P. invites a senior into his home for eleven weeks—to live with him and his family, see all patients with him, even trail him to medical meetings. ¶ Many preceptors have rural practices. The school considers these a more challenging training ground than the big teaching hospital. ¶ The photographs follow a typical student through his apprenticeship.

Dr. E. Sinks McLarty (right), assistant director of extramural education for the University of Texas School of Medicine, has been called the father of this preceptorship program. Here he introduces 24-year-old student Lonnie S. Burnett into the home of his future preceptor, Dr. Solon D. Coleman (center). With four associates, Coleman runs the thirty-bed Brazos Valley Sanitarium, only hospital in Navasota (population: 6,100).

←Dr. McLarty worked out the G.P. preceptorship plan with Drs. Van Goodall of Clifton (left) and Andrew S. Tomb of Victoria, Texas A.G.P. officers.

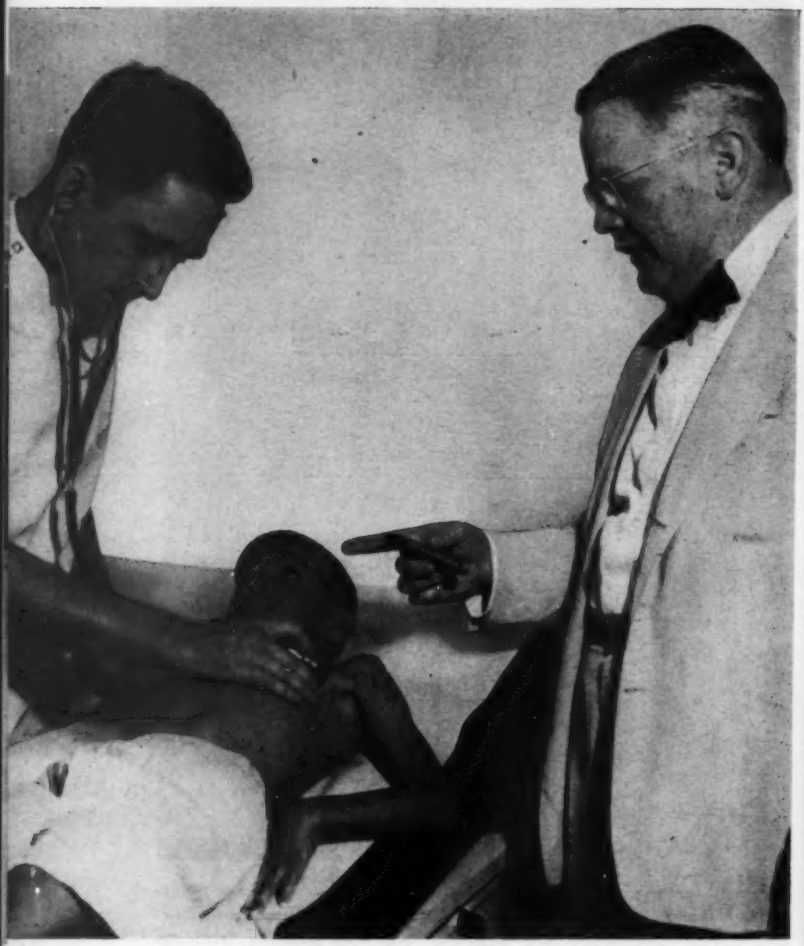
[MORE→

Dr. Coleman supervises Burnett's bedside care of Verlyn Lemon, a ranch foreman's daughter. Directed to spare the student nothing, Coleman starts the young man's day at 6:30 A.M., puts him through the wringer of closely scheduled office hours and hospital routine, keeps him in tow till the last home visit has been made, wakes him for any emergency calls at night.

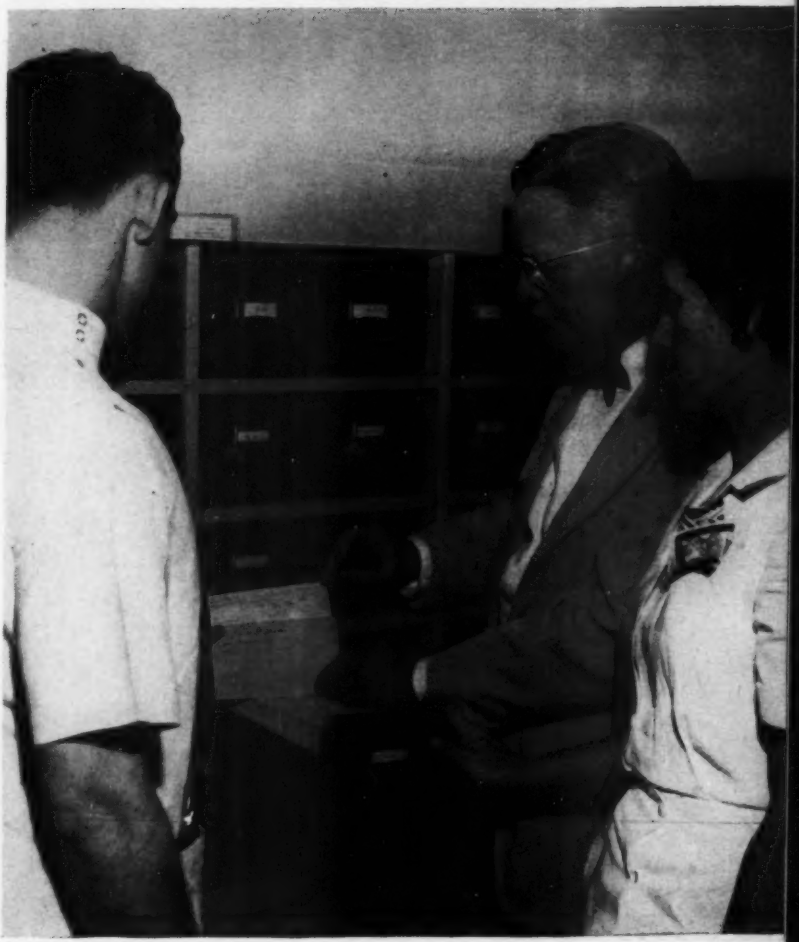


An early lesson: The G.P. snatches a coffee break whenever emergencies permit. Such informal consultations let Coleman and Burnett discuss cases more fully than they can with patients listening.

[MORE→

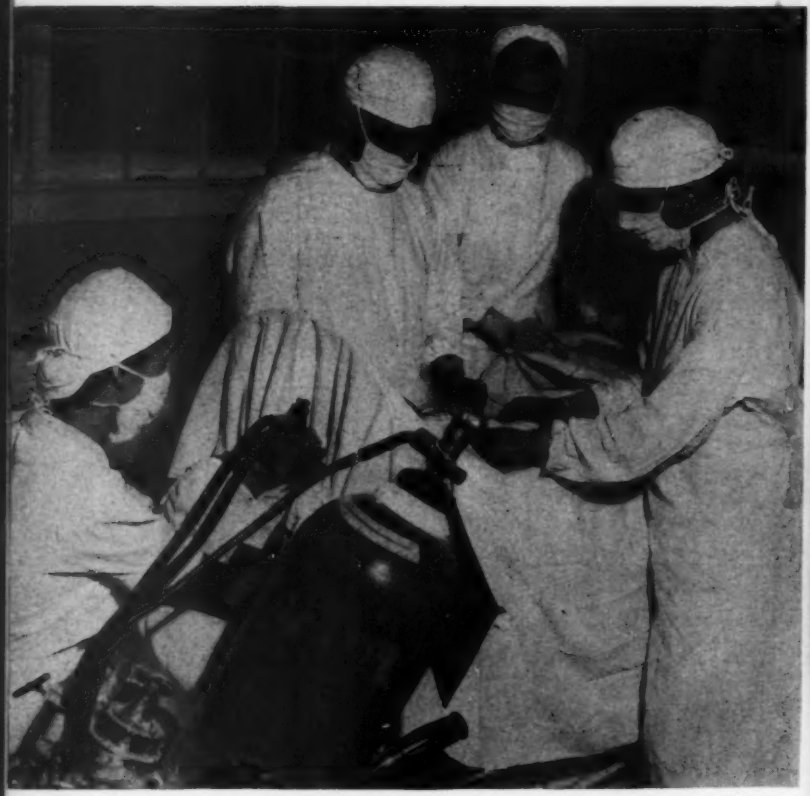


With twenty-eight years of experience, Coleman is well equipped to help a student understand patients. He goes on the assumption that the art of medicine can be caught more readily than taught. And the student gets a chance to apply academic training to actual situations. Here Burnett benefits from his preceptor's guiding finger while examining 8-year-old Otis Brown.

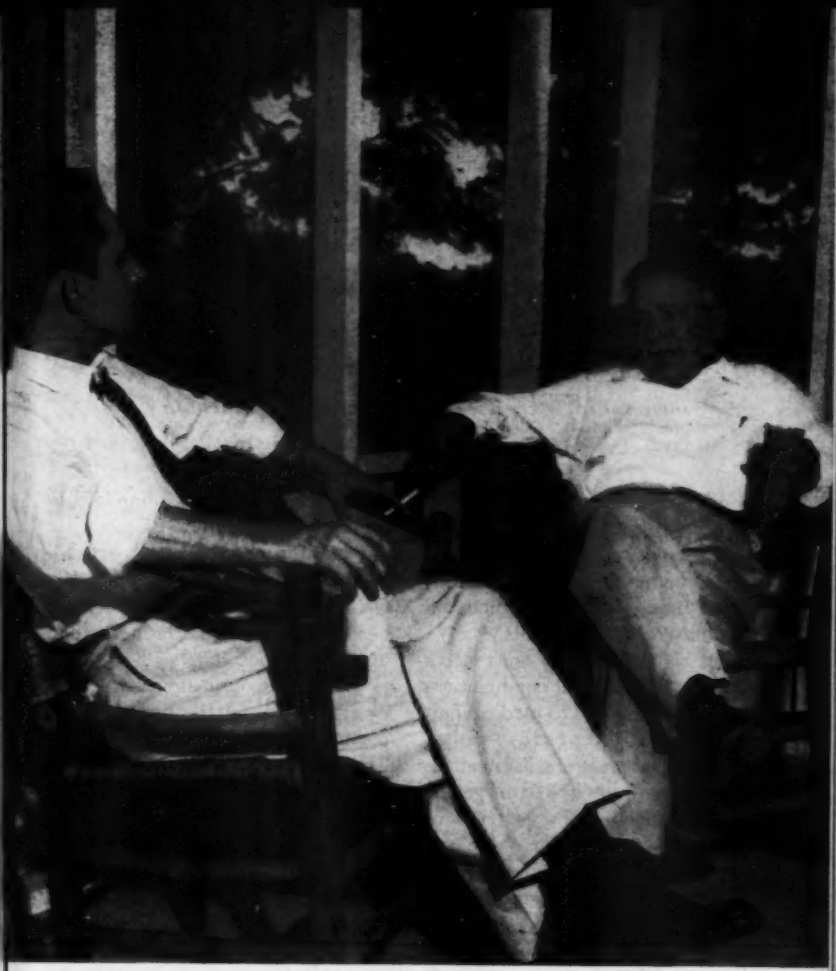


The importance of office-record routine is stressed by Dr. Coleman and Mrs. J. C. Dyer, the clinic's record librarian. The doctor points out that a family physician needs accurate case histories for future reference, when patients and their children return. And he explains the machinery of fee setting and collections—subjects on which textbooks are usually silent.

[MORE→



In the hospital, Coleman initiated young Burnett into surgery as assistant at forty major operations in thirty days. After Burnett had helped with five deliveries, he was able to manage a sixth that caught him alone. Later, when a post-thyroidectomy patient started to hemorrhage, he handled the emergency himself while Coleman was still on his way to the hospital.



"Relax if you want to survive" is a basic lesson for the student. In just such a relaxed mood the preceptor sums up final advice to his apprentice, now ready to return to school. Coleman has helped Burnett acquire confidence and respect for general practice. More important, the student now sees medicine as a human procedure, not just as a scientific exercise.

END

Partnership Practice: How to Get Started

Most successful combinations begin with an expense-sharing agreement or an employment contract. And they usually plan in advance for ownership, expenses, and accounts receivable

• Why do doctors form partnerships? Nearly always, for the same basic reasons: to secure easy consultation, better facilities, better control of time, stabilized income, and disability or death benefits.

But similar motives don't necessarily produce similar combinations. Among more than 125 medical partnerships studied at close range, we've seen successful pairs in almost every specialty field and in general medicine; in cities of several million, and in towns of 500. We've seen men the same age combine successfully, and also men thirty-five years apart.

The circumstances that brought them together have been equally varied—as witness this sampling of combinations known to us:

¶ In Chicago, two well-established surgeons decided to combine. One was 61, the other 44; they had become close friends through work in the same hospital.

¶ In a Wisconsin town of 1,000, two general practitioners became partners. Both were in their forties. They were the only two doctors in town.

¶ In Detroit, two internists joined forces. One was 52 and a part-time professor; the other was 30, a former student of his.

¶ In an Ohio town of 2,500, a family doctor, aged 46, couldn't keep up with his obstetrical work. So

---

By Henry C. Black and Allison E. Skaggs

**This article is the second of a series. The first installment, published in November, dealt with the pros and cons of a partnership. Later installments will cover the division of income, the written agreement, and dissolution provisions. The authors gained their experience in such matters through twenty years of operating Professional Management of Battle Creek, a firm that today has doctor-clients in a dozen states.*

Expense-Sharing Agreement

THIS AGREEMENT made this twentieth day of November, 1952, by and between HAROLD V. HAWKINS, M.D., party of the first part, and CAMPBELL B. SMITH, M.D., party of the second part, WITNESSETH:

WHEREAS, the parties hereto are doctors and desire to engage in their separate practices in the City of Columbia, Indiana, but desire also to share the offices now occupied by first party at 111 Park Avenue, and to procure office personnel together, and to share the expenses therefor on the basis hereinafter set forth, and also to share the use of their respective items of equipment;

NOW, THEREFORE, the parties hereto, in consideration of the mutual benefits to be derived therefrom, do hereby contract and agree as follows:

(1) That the parties hereto shall share the offices of first party at 111 Park Avenue in the City of Columbia, Indiana, and shall share in the joint expenses of operating said offices, including the following items: rent, electricity, salaries for office help, repairs and remodeling, furnishings, drugs, supplies, postage, telephone, and other items of a like nature.

(2) That to provide a fund for the payment of said joint expenses, the parties hereto shall establish a joint bank account, and each shall deposit the initial sum of Two Thousand Dollars ($2,000.00) therein.

(3) That at the end of each month, the said joint expenses paid from said account shall be totaled, and each party hereto shall deposit in said account a sum computed by pro rating the gross business done by each party during said month against the said joint expenditures.

(4) That each party shall continue to own the equipment which he now owns and shall continue to own his separate accounts receivable.

(5) That each party shall separately collect monies due him and may deposit said funds in his own bank account, but that each shall keep careful account of all professional charges and cash receipts and shall make such figures available to the other party as needed for the computation of the said joint expense sharing.

(6) That each party shall have equal authority as to personnel, but neither shall obligate the association for any sum in excess of One Hundred Dollars ($100.00) without the consent of the other party.

This agreement shall become effective on the first day of December, 1952, and shall continue until terminated. Either party may discontinue this agreement by giving the other a notice in writing of such intention on or before the ninetieth (90th) day prior thereto.

IN WITNESS WHEREOF, the parties hereto have hereunto set their hands and seals to this instrument executed in duplicate the day and year first above mentioned.

Witnesses:

J. B. Barnes

Clarence Jacobs

Harold V. Hawkins, M.D.
first party

Campbell B Smith, M.D.
second party

he took on a 34-year-old OB specialist as his partner—the latter a man who had practiced in a neighboring town.

¶ In a medium-size Michigan city, two pediatricians (aged 58 and 38) became full partners after eighteen months of sharing office space.

¶ In an Indiana city, a 62-year-old ENT man signed up a partner just half his age. The latter had originally come from New York as the senior's salaried assistant.

What did these varied combinations have in common? Not only the same basic motives, but also the same basic approach:

Experimentation First

Before combining assets, each pair made certain that the existing practice was growing—that it justified a partnership. Each pair also secured good legal and accounting advice. And each pair made sure of full mutual confidence, usually by trying out practice together first.

How did they try out joint practice? Under (1) an expense-sharing agreement, or (2) a pre-partnership employment contract. Let's take a closer look at each of these:

1. Expense-Sharing Agreement. As shown in the sample on page 99, this enables the doctors to divide operating costs without dividing ownership or income. The same suite is shared; so are secretarial help and professional supplies. All operating expenses are paid out of a reserve fund, which the doctors replenish each month—either equally or in proportion to individual receipts, as agreed.

Expense-sharing is well suited to established practitioners. It offers them many of the professional benefits of full partnership—for example, easy consultation in problem cases; office coverage during one doctor's absence; perhaps more complete diagnostic facilities. What's more, the arrangement can be terminated quickly or continued indefinitely.

Income Isn't Stabilized

But most of the financial benefits of full partnership are missing. There's no income security, since earnings aren't shared; there's no vacation or disability pay. And if one man dies, the other can't be of maximum help in liquidating his practice—which means less money for the dead doctor's widow.

Clearly, expense-sharing is not the same as a partnership. Some doctors, in fact, choose to emphasize the difference. They include in their written agreement a clause like this:

"It is expressly understood that this agreement shall not be construed to create a partnership relationship . . . Each party hereto shall carry on his own separate practice . . . Each party shall have separate stationery, letterheads, and statements . . ."

2. Pre-partnership Employment Contract. Though even less like a partnership, this is more likely to lead to one. Reason: Future plans are stated in some such words

Pre-Partnership Employment Contract

THIS AGREEMENT made this fifteenth day of December, 1952, by and between DAVID R. BLEDSOE, M.D., first party, and LEONARD NOVINGER, M.D., second party, WITNESSETH:

WHEREAS, first party is and has been for several years engaged in the practice of medicine and surgery in the City of Middletown, Michigan, and desires to employ second party to assist him in said practice, and second party desires to accept said employment;

NOW, THEREFORE, in consideration of the premises and mutual benefits to be derived herefrom, the parties hereto do hereby contract and agree as follows:

(1) First party does hereby employ second party to assist him in his said practice of medicine and surgery for a period of one (1) year beginning the second day of January, 1953.

(2) Second party agrees to devote his full time and best efforts to the said practice of medicine and surgery, under the direction of first party.

(3) Second party agrees that all fees which may be charged or collected for his services shall be the property of first party.

(4) First party agrees to pay to second party as compensation for his services the sum of One Thousand Dollars ($1,000.00) per month, payable one-half on the first and one-half on the sixteenth day of each month, less any sums which first party is required to withhold by law.

(5) Second party agrees that he will furnish and maintain his own automobile for his own use as may be necessary or desirable in the said practice. Second party also agrees to maintain memberships in the Middletown County Medical Society and such other hospital staff organizations or professional societies as may be necessary or desirable.

(6) It is the intention of the parties hereto that at the end of the term of this contract they will, if possible, mutually agree to form a copartnership for the practice of medicine and surgery, and that such a contract will specify such a percentage of the net income from said practice to be paid to second party as will amount to not less than his earnings under this contract of employment, and that such percentage shall be progressively increased over a period of five (5) years from the beginning of said copartnership until reaching equality.

IN WITNESS WHEREOF, the parties hereto have hereunto set their respective hands and seals to this instrument, executed in duplicate the day and year first above mentioned.

Witnesses:

Harold Hollister

A.B. Clemmer

David R. Bledsoe, M.D.
first party

Leonard Novinger, M.D.
second party

CAUTION: This contract and the agreement on page 99 are composite samples. They fit no real-life cases exactly. They should not be adapted for actual use without legal advice.

as these: "It is the intention of both parties hereto that at the end of the term of this contract they will, if possible, mutually agree to form a partnership . . ."

In equally tentative terms, the contract can specify that the employed physician will receive not less than his present income when the partnership starts; also, that his share of the partnership income will be progressively increased until it equals the senior member's share after a specified number of years. (The wording commonly used appears in the sample pre-partnership employment contract that is reproduced on page 101.)

Salary Plus Bonus

This, of course, is the familiar "assistant arrangement," with trimmings. It's appropriate where one doctor is much younger than the other; where the junior M.D. is long on training but short on experience. He's generally paid a straight salary to begin with—from $500 to $1,000 a month, nowadays. This may be supplemented later by a percentage of profit.

The prospect of a partnership keeps the young man from breaking away. Meanwhile, under the senior's direction, he gets full opportunity to prove himself.

If things work out as expected, the transition to full partnership is smooth. If, on the other hand, something goes wrong, this arrangement isn't difficult to dissolve. No expense funds have been pooled, no assets have been combined, no irrevocable commitments have been made.

Decision for Doctors

Up to this point, we've been talking about partnership preliminaries —the things doctors should consider before making *any* final decision. Eventually, however, they've got to decide one question for themselves: "Is partnership practice what we really want?"

Perhaps they'll find this decision easier to make if they look ahead a bit. Suppose two or three doctors have already made up their minds to combine. How do they go about getting started?

First, by threshing out their ideas on the way they want to operate—ideas that can later be written into their partnership agreement.

Help Wanted

This idea-threshing needn't be done unaided. Both a qualified attorney and an experienced accountant can (and should) contribute to it. But much of the earliest planning depends on the doctors themselves. For example:

Once they've decided on a partnership, they need to do some advance thinking about ownership of assets, policy control, accounts receivable, partnership expenses, and the handling of partnership patients —to say nothing of income division. This last-named item rates a chapter by itself, but the rest can be highlighted briefly.

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for prolonged use

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without drug hangover

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With DORMISON, there is no prolonged suppressive action. Patients enjoy natural, restorative sleep—awaken alert and refreshed with no barbiturate-like hangover. DORMISON's extraordinarily wide margin of safety permits the prematurely awakened patient to repeat the dose, if necessary, without hazard or penalty of mental depression upon arising.

Dosage: Two 250 mg. capsules taken with a glass of cold water or milk. Many patients will be found to respond to only one capsule.

DORMISON* (methylparafynol-Schering), capsules of 250 mg., bottles of 100.

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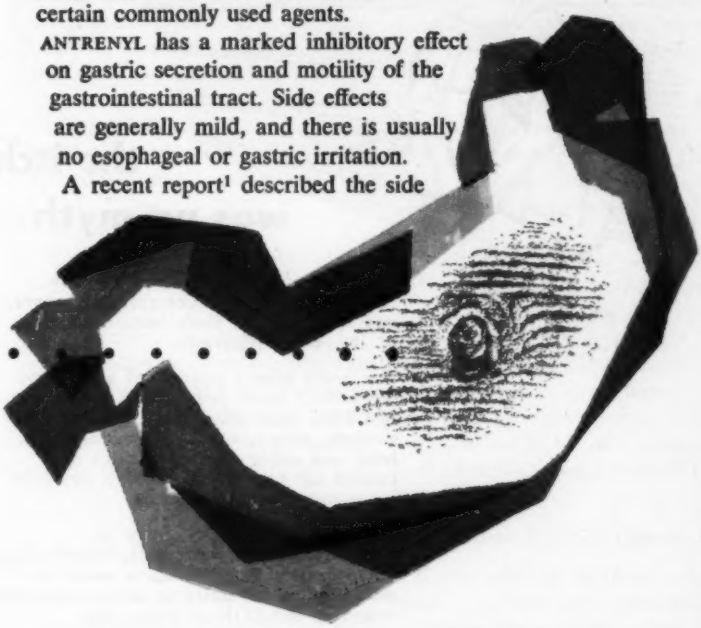
ANTRENYL bromide is a new high potency anticholinergic agent indicated in the management of peptic ulcer and spasm of the gastrointestinal tract.

Milligram per milligram, it is the most potent of the newer anticholinergics, recommended dosage being only about *one-tenth* that of certain commonly used agents.

ANTRENYL has a marked inhibitory effect on gastric secretion and motility of the gastrointestinal tract. Side effects are generally mild, and there is usually no esophageal or gastric irritation.

A recent report[1] described the side



effects as less pronounced than those of other drugs ordinarily used in the management of peptic ulcer. In this study, patients receiving ANTRENYL usually obtained relief from acute symptoms within 24 to 36 hours.

Prescribe ANTRENYL as adjunctive therapy in your next few cases of peptic ulcer and note its advantages. Available as ANTRENYL Bromide Tablets, 5 mg., scored; bottles of 100, and as ANTRENYL Bromide Syrup, 5 mg. per teaspoonful (4 cc.); bottles of 1 pint.

Ciba

Ciba Pharmaceutical Products, Inc., Summit, New Jersey

1. Rogers, M. P., and Gray, C. L.; *Am. J. Digest. Dis.*, 19:180, 1952.

the itch was no myth...

No part of Greek mythology was "the itch". The Greeks called it *psora*, and we carry on their terminology in the word *psoriasis*.

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commonly asked by partners-to-be:

What capital investment does a partnership require?

Usually, not much. Each doctor contributes the equipment, instruments, and furnishings he already owns. Suitable office space can generally be obtained on a rental basis; thus there's no big building-fund requirement—the No. 1 problem of larger medical groups. Nearly all the small partnerships we've seen have started with small cash outlays.

Who Owns What?

On what basis is ownership of the capital assets arranged?

On an equal basis, as a rule—regardless of how earnings are divided at first. Most two-man partnerships eventually arrive at a 50-50 division of income, and it simplifies bookkeeping tremendously if ownership is arranged the same way right from the start.

Of course, some partners prefer to share ownership just as they share income: on a shifting percentage basis. But any such M.D. inevitably ends up owning different percentages of different assets—for example, 35 per cent of an X-ray machine; 40 per cent of a BMR unit acquired later on; 50 per cent of a laboratory set-up installed still later. Small wonder that he has trouble keeping track of exactly what he *does* own!

Equalizing Ownership

How is equal ownership possible if the partners contribute different amounts in capital assets?

Their investment can be equalized by a cash transaction between them or by gradual repayment of the short-end doctor's debt. Here's an example:

Two Illinois internists decided to form a partnership. They listed all their equipment, then computed its book value (original cost less allowed depreciation). One doctor's equipment was only two years old, so it hadn't depreciated much (book value: $5,000). The other man had about the same amount of equipment, but it was eight years old (book value: $2,000).

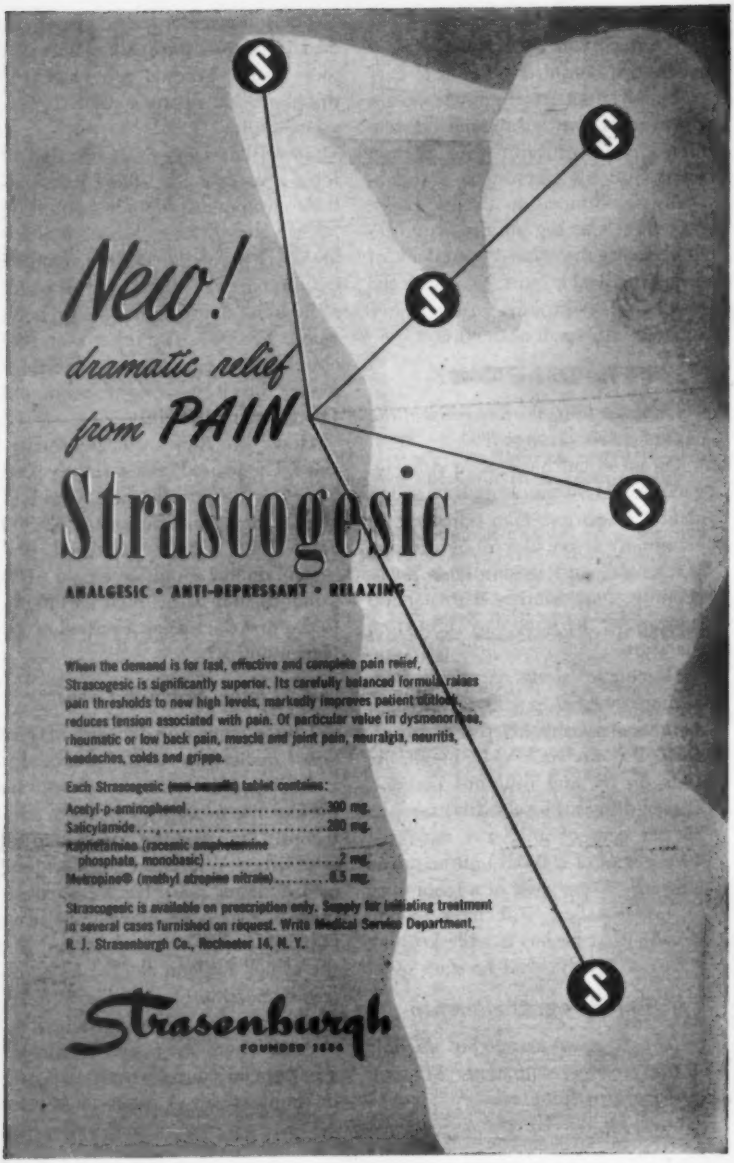
How did they equalize ownership? The second doctor simply paid $1,500 in cash to the first, thus balancing their contributions at $3,500 apiece. (If they'd preferred, the second doctor could have paid $100 a month—out of his *own* earnings—to the first doctor for a period of fifteen months.)

Three Special Cases

Under what conditions might equal ownership not be practical?

Perhaps, for example, where one partner has *no* capital assets to contribute. This was the case when an established Wisconsin surgeon took in a younger man, fresh from residency. Ownership *could* have been equalized without much strain; but the senior surgeon elected to retain sole ownership of assets until a 50-50 income division was reached.

Also, where one doctor dominates a partnership, equal ownership may be impractical. A three-man com-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Strascogesic
ANALGESIC • ANTI-DEPRESSANT • RELAXING
When the demand is for fast, effective and complete pain relief, Strascogesic is significantly superior. Its carefully balanced formula raises pain thresholds to new high levels, markedly improves patient attitude, reduces tension associated with pain. Of particular value in dysmenorrhea, rheumatic or low back pain, muscle and joint pain, neuralgia, neuritis, headaches, colds and grippe.
Each Strascogesic (non-narcotic) tablet contains:
Acetyl-p-aminophenol ..... 300 mg.
Salicylamide ..... 200 mg.
Ephedamine (racemic amphetamine phosphate, monobasic) ..... 2 mg.
Metropine® (methyl atropine nitrate) ..... 0.5 mg.
Strascogesic is available on prescription only. Supply for initiating treatment in several cases furnished on request. Write Medical Service Department, R. J. Strasenburgh Co., Rochester 14, N. Y.
Strasenburgh
FOUNDED 1884

bination on the West Coast provides a case in point. The founding partner has the biggest reputation, draws most of the patients, and will probably always be alloted more than one-third of the income. He owns 50 per cent of the capital assets; the other two partners own 25 per cent apiece.

And where one prospective partner owns a medical building, we often recommend that he merely rent it to the partnership. If the building were counted as a contributed asset, it might cost the second partner $15,000 to equalize ownership—an unnecessarily high getting-started price. Besides, partnerships are easier to manage (and to dissolve) when real estate is excluded.

Who Gets Last Word?

If ownership is equal, who exercises policy control?

In our experience, this isn't much of a problem. Most successful partnerships are based on artful compromise, and doctors who *can't* compromise generally stay in solo practice (or soon return to it). Nevertheless, a "control" clause can be used to rule out minor deadlocks. Here are three common forms:

¶ "Dr. Senior shall make all decisions as to the policy to be pursued by the partners, if there is disagreement upon such policy, and his decisions shall be final."

¶ "No major changes in procedure or policy shall be effected without the permission of the senior partner."

¶ "In all matters of policy, the decision of the partner drawing more than 50 per cent of the net income of the partnership shall be determinative and binding."

Cash Coming In

What about accounts receivable at the time the partnership is formed?

These are a problem, all right. Each doctor comes into partnership with varying amounts in outstanding bills. He's earned this income on his own, but it will be collected after the partnership starts. Who gets the money—the individual doctor, or the partnership as a whole?

While the first answer sounds the simplest, the second is often best. Bookkeeping problems multiply if you try to distinguish between individual income and partnership income. And in a senior-junior combination, if each man collects his own bills, the junior may have nothing to live on the first few months. (It's not uncommon for the senior to have $20,000 owed him by patients, the junior to have nothing owed him at all—since he's never had patients of his own.)

Arranging Fair Shares

If these accounts receivable are collected through the partnership, how can each doctor be assured of his appropriate share?

First, the partners estimate such receipts in advance. Then they decide how much one doctor will be indebted to the other if the partner-

ship takes over these accounts. Finally, they agree on a schedule for paying off this indebtedness.

In effect, one man "buys into" the other's accounts receivable, on the installment plan. The following examples show how this can be arranged:

Two ophthalmologists in Ohio decided to become equal partners, after several months of expense-sharing. In round figures, one man had $15,000 on the books; the other man, $10,000. Collectibility was estimated at 80 per cent.

Thus, they figured, one doctor would be contributing $4,000 more than the other to the partnership when it took over both sets of accounts. Half this amount—$2,000—represents the second man's indebtedness to the first. (That's what it would take, in a cash transaction between them, to equalize their contributions.)

Their solution? An installment payoff of $200 a month for the first ten months, out of the low man's *own* earnings. These payments would go to the better-established partner as compensation for his excess receivables.

In the case of two Michigan practitioners—one a salaried assistant moving up to partnership—the difference in receivables was much greater. The senior's patients owed him about $18,000; the junior's patients didn't owe him anything. Collections had been running around 90 per cent. So when the partnership took over all outstanding bills, it put the junior an estimated $16,200 behind in his contributions to the partnership.

The pay-off agreed on was $1,000 a month—the senior to take this amount out of partnership earnings *before* they were divided. Thus, in a little more than sixteen months, the difference in receivables would be wiped out.

Expense-Account Problem

Which professional expenses should be borne by the partnership, and which by the physicians individually?

This depends in part on the way the partners plan to operate. For example, should they charge all auto expenses to the partnership? Or should they impose a limit of, say, $50 a month? Though such a limit is quite common, it would be unfair if one partner agreed to take most of the house calls.

In our experience, partners frequently agree to pay the following items out of their *own* pockets: convention-connected outlays, as for meals, hotels, transportation; money spent for medical books; auto expenses above a specified limit; and professional entertainment costs.

Though these are clearly professional expenses, they're incurred on a personal basis. No two partners would be likely to turn in similar expense accounts. So it's frequently thought best not to charge these items up to the partnership.

Most other professional expenses *are* charged up: rent, salaries, sup-

BUTAZOLIDIN

brand of phenylbutazone

for rapid relief of pain and functional improvement in arthritis and allied disorders

Gouty Arthritis . . . Osteoarthritis . . . Rheumatoid Arthritis
Psoriatic Arthritis . . . Spondylitis

For relief of pain associated with:
Bursitis . . . Fibrositis . . . Myositis . . . Sciatica
. Muscular Rheumatism . . . Scapulo-humeral Periarthritis

Advantages:

Broad Spectrum including virtually all arthritic disorders.

Potent Effect shown by relief of pain, often with functional improvement.

Prompt Action evidenced usually by clinical improvement in 24-48 hours.

Effectiveness by Mouth in dosage of 600-800 mg. daily.

for relief of

ARTHRITIS and allied disorders

rapid relief of pain reported in
85% of patients with *rheumatoid arthritis*[1-6]
100% of patients with *acute gout*[1,5]
67% of patients with *osteoarthritis*[1]
96% of patients with *spondylitis*[1,6]
94% of patients with *peritendinitis*[1,2]

***functional improvement,* Grade I or II,**
has been reported in nearly half the cases of rheumatoid arthritis treated with BUTAZOLIDIN. In gout, complete remission or major improvement has been obtained within 48 hours in 86.5% of cases.[1,5] In virtually all arthritic disorders, functional improvement — reduced swelling and increased mobility — frequently results from BUTAZOLIDIN therapy.

BUTAZOLIDIN is well within the means of the average patient.

In order to obtain optimal results and to avoid untoward reaction it is highly desirable for the physician to become thoroughly acquainted with the characteristics of BUTAZOLIDIN before prescribing it. Physicians are urged to read the package circular carefully or to write for the brochure, "Essential Clinical Data on BUTAZOLIDIN," which will gladly be sent on request.

BUTAZOLIDIN® (brand of phenylbutazone) issued in yellow-coated tablets of 200 mg. and in red-coated tablets of 100 mg.

References:

1. Kuzell, W. C., and Schaffarzick, R. W.: Paper read before the California Medical Association, Los Angeles, April 29, 1952.
2. Smith, C. H., and Kunz, H. G.: J. M. Soc. New Jersey 49:306, 1952.
3. Currie, J. P.: Lancet 2:15 (July 5) 1952.
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5. Kuzell, W. C.; Schaffarzick, R. W.; Brown, B., and Mankle, E. A.: J.A.M.A. 149:729 (June 21) 1952.
6. Holbrook, W. P.; Stephens, C. A. L., Jr.; Yeoman, E. E.; Hill, D. F., and Goodin, W. L.: Personal communication — July 16, 1952.

Geigy

GEIGY PHARMACEUTICALS

Division of *Geigy Company, Inc.*, 220 Church Street, New York 13, N. Y.

Prejudice-Free Study Points the Way to Greater Comfort for the Menopausal Patient

Three groups of investigators were supplied with preparations labeled only by number. Although identical in appearance, the tablets had the following compositions:

AE-1—Diethylstilbestrol, 0.25 mg.
AE-2—Diethylstilbestrol, 0.25 mg., plus methyltestosterone, 5 mg.
AE-3—Methyltestosterone, 5 mg.
AE-4—Placebo

Investigators were told which was the placebo, but identities of the first three were not disclosed until the studies and reports had been completed. Thus, there could be no possible bias on the part of either physician or patient.

Clinicians found that the addition of androgen to estrogen (1) often affords an increased feeling of well-being, (2) tends to avert mild but unpleasant side-effects such as breast turgidity and pelvic congestion, and (3) usually prevents the complication of uterine bleeding. *Preference for AE-2 ('Tylosterone') was expressed by two-thirds of the patients.*

Full details of these studies are available. May we send you literature or samples?

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Lilly

Helps avert side-effects of estrogen therapy

TABLETS

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plies, maintenance, depreciation, practice-connected insurance, and such. There's a great deal to be said, in fact, for paying *all* income-tax-deductible expenses through the partnership: It helps clinch their deductibility.

Patients Often Pooled

How far should partners go in combining their practices?

This, too, depends on the individual case—and hence deserves planning in advance. Nearly half the partnerships we've worked with have, in effect, pooled their patients. The others have kept them as patients of the doctor first, the partnership second.

Where both partners already have substantial followings, divided practices may work out well. Of course, each partner checks with the other on difficult cases; each sees the other's patients in emergencies. But most of the time, under this arrangement, each partner sees his own patients exclusively.

Where one doctor starts with many more patients than the other, a wholly combined practice is apt to be preferable. The choice is really up to the doctors; it depends largely on what they think their patients want.

How to Combine

Can the partners pool their patients gradually?

Yes, they can—and they probably should. Here's the way two Michigan OB men arranged it:

The junior partner began by taking house calls and (in company with the senior) making hospital visits. Pretty soon, new patients phoning the office for an appointment with the senior were told something like this:

"I'm afraid he's pretty well booked up for the present. But, if you like, I think I can arrange an immediate appointment with the doctor's new associate . . ."

Most new patients accepted this proposition. And, after a while, it was extended to the old ones.

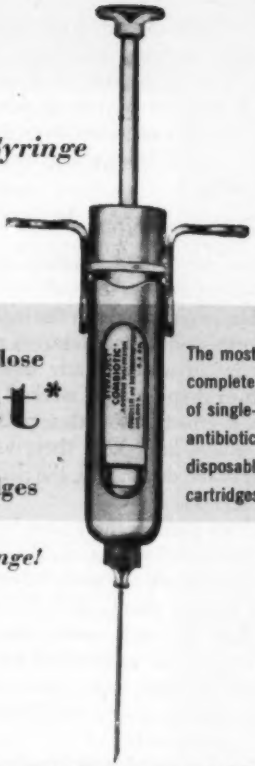
Today *all* patients are routed to the senior man on one visit, to the junior man on the next. They're impressed by the ease with which one partner can cover for the other. And they're kept from feeling too dependent on one obstetrician—who may be out of town, or off on another case, come D-Day.

What are the best ways to divide partnership income?

This is the jackpot question—the most important one to consider in advance. We'll devote our next installment to answering it. END

NEW *Pfizer Steraject Syringe*

holds 2 cartridge sizes



sterile, single-dose

Steraject*

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The most complete line of single-dose antibiotic disposable cartridges

2 cartridge sizes for only 1 syringe!

NEW

Steraject Penicillin G Procaine Crystalline In Aqueous Suspension (300,000 units)

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two cartridge sizes permit *full standard* antibiotic dosage

cartridges individually labeled

ready for immediate use

no reconstitution

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each one supplied with sterile needle, foil-wrapped

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Your 1953 Federal Tax Timetable

Jan. 15 Either (1) pay the balance due on your estimated tax for 1952 (remembering that if end-of-the-year tallies have shown your previous estimates to be incorrect, you may need to file an amended estimate to avoid penalty). Or (2) file your final return for 1952 and pay the balance due.

Jan. 31 File Form 941 showing taxes withheld from your employes and old-age benefit taxes for the last quarter of 1952; then pay amounts due. Give your employes original and duplicate receipts (Form W-2) for all taxes withheld from their 1952 pay. Send Collector of Internal Revenue the triplicate copy of each Form W-2, with annual reconciliation form (W-3).

Mar. 15 File your final return for 1952 if you haven't done so already, and pay the balance due. File your declaration of estimated tax for 1953 and pay one-fourth the total estimated tax.

April 30 File Form 941 showing taxes withheld from your employes and old-age benefit taxes for the first quarter of 1953. Pay amounts due.

June 15 Pay second quarterly installment of your estimated 1953 tax. Or file an amended declaration and pay one-third of the balance due.

July 31 File Form 941 showing taxes withheld from your employes and old-age benefit taxes for the second quarter of 1953. Pay amounts due.

Sept. 15 Pay third quarterly installment of your estimated 1953 tax. Or file an amended declaration and pay one-half the balance due.

Oct. 31 File Form 941 showing taxes withheld from your employes and old-age benefit taxes for the third quarter of 1953. Pay amounts due.

Whenever dates shown fall on Saturday or Sunday, tax returns are due *on the next business day.*

Whole Wheat

IN ITS MOST DELICIOUS, CONVENIENT FORM

When the convenience offered by a ready-to-eat cereal is required to assure the patient's cooperation, so many doctors recommend

WHEAT CHEX!

WHEAT CHEX is made of whole wheat, ready to eat without fixing.

It's bite size for easy eating. Specially prepared for easy digestion. Has a delicious flavor that stimulates lagging appetites. Lasting crispness in cream or milk to make the last bite as tempting as the first.

Recommend **WHEAT CHEX** for breakfast—for between-meal and bedtime snacks instead of sweets.

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"...and be sure to take your VITAMINS!"

Lactation increases vitamin requirements at a time that is critical to mother and child. A balanced vitamin preparation is a dependable way of forestalling the development of a deficient state.

MERCK & CO., INC., RAHWAY, N.J.—as a pioneer manufacturer of Vitamins—serves the Medical Profession through the Pharmaceutical Industry

About the Seventh MEDICAL ECONOMICS Survey:

[SEE PAGE 71]

• It was in 1929—a few months before the stock market crashed—that MEDICAL ECONOMICS published the results of its first survey of the economic status of U.S. physicians. More recent surveys, made every few years since then, have examined the doctor's practice through the lean days of the depression, the exhausting days of World War II, and the unsettled days of the post-war period.

The Seventh MEDICAL ECONOMICS Survey is the most comprehensive yet attempted. Like earlier ones, it was planned and prepared for publication by the editorial staff of this magazine, with the technical aid of consultants in research and statistics. The detailed statistical work was done by Columbia University's Bureau of Applied Social Research.

Who participated in the study? Copies of the questionnaire were sent by direct mail to a cross-section totaling about one-third of the country's active, private physicians. It was also published in the April, 1952 issue of the magazine—which circulates, of course, to almost all private practitioners. Excluded from the survey group were doctors over 65, internes, residents, and medical men in full-time government service.

About 8,000 questionnaires were returned by the time statistical work was begun. Since this was a considerably larger sample than necessary for stable results, a free hand was used in discarding incomplete or inaccurate returns.

Other questionnaires were eliminated in order to make sure that the sample constituted a valid cross-section of doctors the country over. Actually, the unadjusted sample closely approximated the known distribution of physicians by three key variables: community size, geographic area, and years in practice. But it included a somewhat too great proportion of full specialists in relation to partial specialists and general practitioners. So, by means of a system of random discarding that preserved the close correlation with the other three variables, a number of questionnaires from full specialists were removed.

The sample thus arrived at contained 5,009 questionnaires. Of these,

In correcting constipation....

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- produce a unique fecal-softening effect;
- promote easy elimination without stimulation;
- appeal to patients because of its pleasant taste, easy administration.

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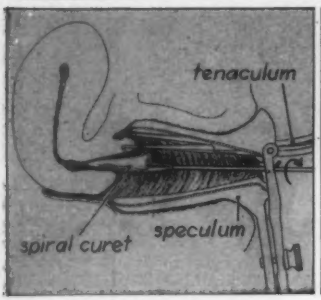
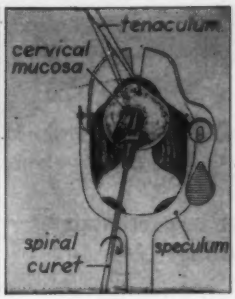
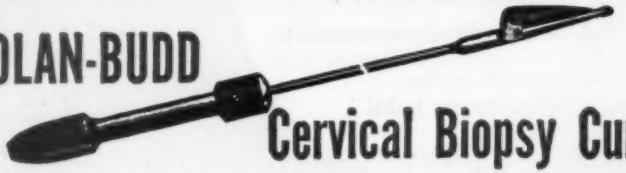
provides, per tablespoonful, sodium carboxymethyl-cellulose (0.36 Gm.) in its most active, hydrated form with magnesium hydroxide (0.6 Gm.) in less-than-laxative dosage, to maintain hydration of the gel by osmosis.

Clay-Adams News





NOLAN-BUDD Cervical Biopsy Curet



FEATURES...New curet* means *simple procedure for the doctor*—can be carried out in the office without anaesthesia. *Simplifies work of pathologist*—utilizes routine paraffin embedding, microtome sectioning, staining with hematoxylin and eosin, and microscopic study.

CLINICAL PROCEDURE

No anaesthesia is required. The cervix is grasped with a tenaculum. The curet is introduced gently into the cervical os with rotation in a counter-clockwise direction until it is inserted as high as possible in the canal. The material collected in the cup is then transferred to the surface of a small square of paper with an applicator stick.

MICROSCOPIC TECHNIC

The collected blood, mucus and tissue are fixed and embedded as with other tissue specimens. Staining is carried out in the usual manner with hematoxylin and eosin. Time for preparation is the same as for other routine biopsies. Examination is facilitated since the tissues are concentrated in a small space on the slides.

E-425/35 Nolan-Budd Cervical Biopsy Curet...ea. $20
Form 5158 gives complete details.

**J. F. Nolan, M.D., and J. W. Budd, M.D., Los Angeles Tumor Inst., Cancer, 4, 6, Nov. 1951, pp. 1367-1371.*

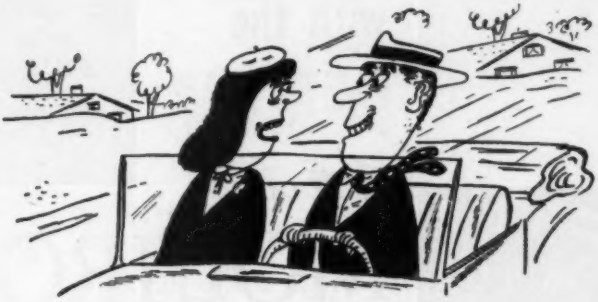
HERE IS A PARTIAL LIST OF OUR PRODUCTS

Adams Centrifuges — Kahn Uterine Cannula
Gastro-Duodenal Tubes — Polyethylene Tubing
MEDICHROMES—2 x 2" — Cytology Outfits
Kodachromes — Anatomical Models
Clinical Laboratory Supplies
GOLD SEAL Slides & Cover Glasses

4,268 were returns from independent doctors (i.e., those who derive more than half their net income from non-salaried practice). Except where otherwise qualified, the survey breakdowns are based on the replies of these independent practitioners alone.

Results of the survey are being presented, several topics a month, in MEDICAL ECONOMICS. Breakdowns are made by such factors as years in practice, city size, geographic area, and specialty. The survey results are also being published in booklet form. END

This is a condensation of a more detailed discussion of the purposes and methods of the Seventh MEDICAL ECONOMICS Survey. For the full text, see the October, 1952 issue.



"Would you like to see where I was vaccinated?"

The only "broad spectrum" hematinic containing molybdenized ferrous sulfate.

If the patient's anemia is amenable to oral therapy it will respond to Mol-Iron E.M.F.

Supplying effective amounts of all the known essential hematopoietic factors, Mol-Iron E.M.F. is a potent therapeutic agent for iron deficiency anemia and many megaloblastic anemias.

EACH MOL-IRON E.M.F. CAPSULE CONTAINS:

MOL-IRON.....198 mg.
(MOLYBDENIZED FERROUS SULFATE)

VITAMIN B_{12} CONCENTRATE.....10 mcg.
(ACTIVITY EQUIVALENT)

GASTRIC SUBSTANCE.....250 mg.

DESICCATED LIVER.....100 mg.

FOLIC ACID.....0.85 mg.

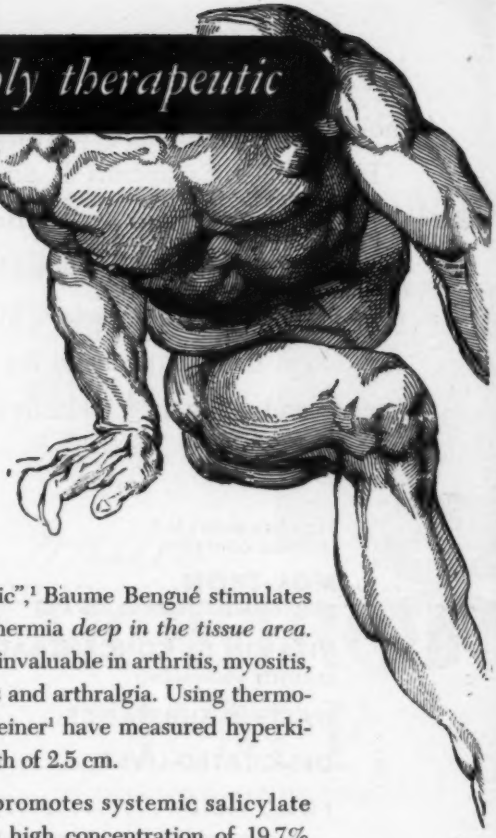
ASCORBIC ACID.....50 mg.

RECOMMENDED THERAPEUTIC DOSE: 2 CAPSULES T. I. D.

BOTTLES OF 100 AND 1000

To date 12 reports on Mol-Iron have appeared in medical literature; all concur in the conclusion that Mol-Iron is more effective and better tolerated than unmodified ferrous sulfate and other iron salts. White Laboratories, Inc., Pharmaceutical Manufacturers, Kenilworth, N. J.

thoroughly therapeutic



As a true "hyperkinemic",[1] Baume Bengué stimulates hyperemia and hyperthermia *deep in the tissue area.* This thorough action is invaluable in arthritis, myositis, muscle sprains, bursitis and arthralgia. Using thermo-needles, Lange and Weiner[1] have measured hyperkinemic activity at a depth of 2.5 cm.

Baume Bengué also promotes systemic salicylate action. It provides the high concentration of 19.7% methyl salicylate (as well as 14.4% menthol) in a specially prepared lanolin base to foster percutaneous absorption.

1. Lange, K., and Weiner, D.: J. Invest. Dermat. 12:263 (May) 1949.

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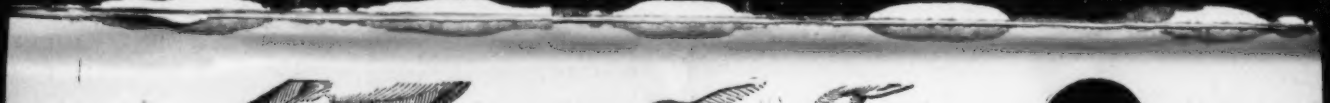

A cough medication—

"significantly superior"

Carefully controlled tests on 52 institutionalized patients have led to the conclusion[1] that "in all important categories, the glycerol guaiacolate preparation (Robitussin) was *significantly superior*" to the recognized remedies ammonium chloride and terpin hydrate.

Robitussin 'Robins' employs not only glyceryl guaiacolate—shown to have maximum effectiveness for increasing respiratory tract secretions[2] and reducing coughing spells[3]—but also desoxyephedrine hydrochloride, for relieving bronchiolar constriction[4] and improving the patient's mood.[5] An exceptionally palatable syrup, for both adults and children.

References: 1. American Practitioner and Digest of Treatment, 2:844, 1951. 2. J. Pharmacol. & Exper. Therapy, 87:24, 1946. 3. Ibid, 73:65, 1941. 4. J. Pharmacol. 77:324, 1943. 5. J. Lab. & Clin. Med., 28:605, 1943.

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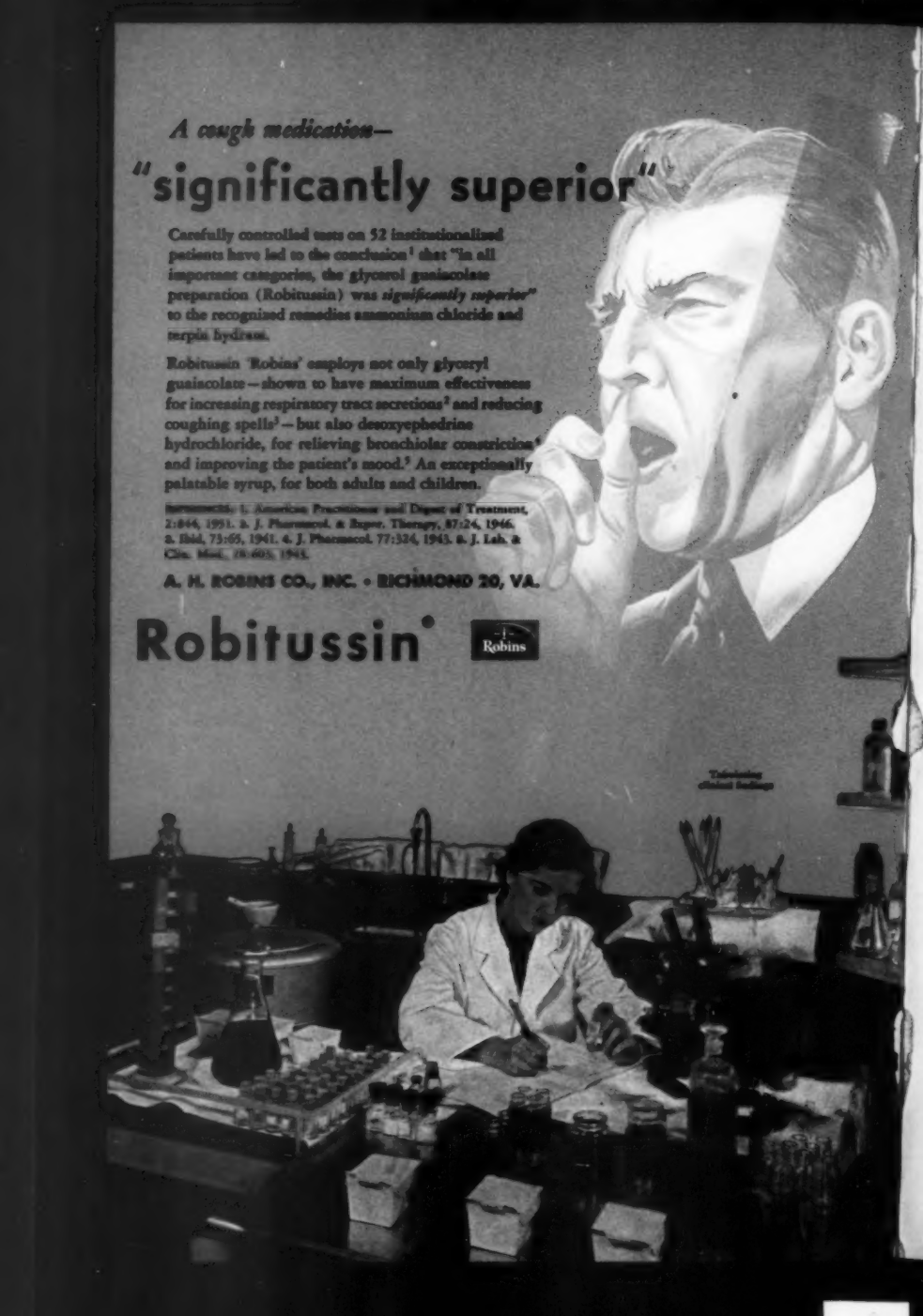
Robins



They Hired a Result-Getter

What Phoenix doctors received in a year, with the help of their first paid executive

● For five years, the physicians in Phoenix, Ariz., had talked about underwriting a bang-up public service program. But the talk had never resulted in action—possibly because of an unspoken question in the minds of many: "How, exactly, will we doctors benefit?"

Just a year ago last June, the impasse was finally broken: The doctors hired their first lay executive. Since then, they've learned that such a program can mean a lot to them personally—in help with their practices, in dollars and cents.

The eye-opening results can be traced in large part to the type of person they hired. Fred Mitten, their new executive, had been an experienced sales consultant in New York. He came to Arizona in search of relief for his wife's arthritis, and he stayed to infuse sound business ideas into the activities of Phoenix doctors.

"If there's one thing a medical society executive should do," says Mitten, "it's to give the doctors a real plus in medical economics."

With Mitten's shoulder behind their various programs, the 300 members of the Maricopa County Medical Society have been making up for lost time—and attracting national attention in the process. Not long ago, the A.M.A.'s director of public relations told them in some astonishment: "It usually takes a county medical society four or five years to accomplish what you have done in less than one."

How have Phoenix doctors helped themselves while helping the public too? Here are some of their most practical ideas—all of them put into effect since Fred Mitten came on the job:

Doctors' accounts audited free. Five months after it started, the society's new collection bureau was operating in the black. Today it's helping to pay off the mortgage on the society's headquarters building at the rate of $5,000 a year. But it had one peculiar problem to overcome first:

Because Phoenix has a high proportion of health-seeking transients, nearly half the accounts that doctors turned over to the collection bureau were "skips"—present address unknown. To stimulate collec-

---

By James C. Fuller

WITH PRESTONE BRAND ANTI-FREEZE

You're SET

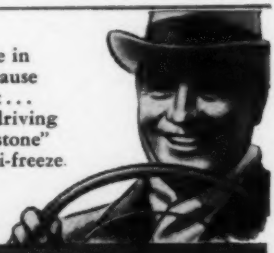
Just put "Prestone" anti-freeze in and forget it till spring! No "boil-away" worries...no repair bills—its special inhibitors give the world's best protection against rust, clogging and foaming.

You're SAFE

High compression engines and efficient car-heaters make non-evaporating anti-freeze more important now than ever. There's not one drop of boil-away alcohol or methanol in "Prestone" anti-freeze.

You're SURE

With "Prestone" anti-freeze in your car, you're sure—because you're safe and you know it... whatever the weather or driving conditions. You have "Prestone" brand, America's No. 1 anti-freeze. It's guaranteed!



NO OTHER ANTI-FREEZE GIVES YOUR CAR THE SAME COMPLETE PROTECTION!

$3.75 PER GAL. | $1.00 PER QT. IN QUART CANS

NATIONAL CARBON COMPANY
A Division of Union Carbide and Carbon Corporation
30 East 42nd Street, New York 17, N. Y.

tions from such patients *before* they migrated, the bureau set up a free auditing service for doctors. It works this way:

Credit Losses Curbed

On invitation, a bureau representative sifts through the doctor's accounts and picks out those that are overdue. These are checked against the bureau's master list of people with bad credit records. Then, in cases where the doctor requests it, collection action can be started immediately.

At first, it was feared that many doctors might resent this service as a reflection on their business methods. Yet a few days after it was announced, fifty M.D.'s had asked for the audit. Several conceded it was the first major housecleaning their accounts had ever received. Today, as a result, the exceptionally high credit losses of Phoenix doctors (formerly, about $1 million a year) are being rapidly cut down.

Unexpected Fees

Anesthetists' fees explained and clarified. Too few surgical patients had been prepared for the separate anesthesia charge. Shocked when they got an unexpected bill, they often blamed the surgeon. Many even protested to the Phoenix grievance committee.

So the medical society and the local anesthetists teamed up to distribute a small, four-page folder. In simple language, it describes the anesthetist's role and explains why his fee isn't included in the surgeon's or the hospital's bill. Since Phoenix physicians began handing these folders to pre-operative patients, the grievance committee hasn't received a single complaint about anesthesia fees.

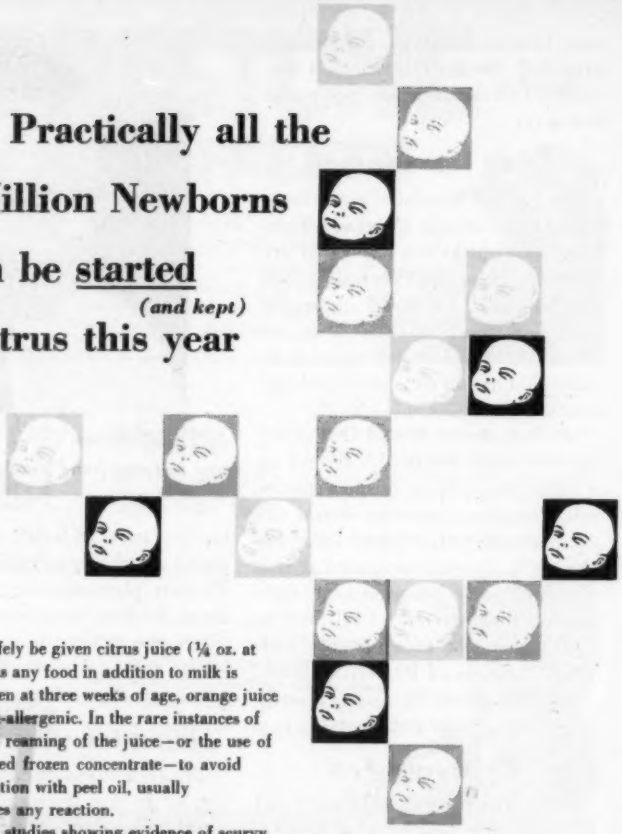
Fred Mitten
Helping hand for doctors

Direct Insurance Benefits

Health insurance proceeds assigned to the doctor. In Phoenix, nearly four out of five insurance checks intended to pay doctor bills had been going astray. Families often spent the windfall for household needs, letting the doctor wait. Sometimes new fathers celebrated by "drinking up" their insurance benefits in local taprooms. When dunned for money they'd already spent, such people tended to blame the insurance company or the doctor, not themselves.

[MORE→

Practically all the 3.5 Million Newborns can be started *(and kept)* on Citrus this year



Newborns can safely be given citrus juice (¼ oz. at first) as soon as any food in addition to milk is permitted. Even at three weeks of age, orange juice is virtually non-allergenic. In the rare instances of sensitivity, gentle reaming of the juice—or the use of specially prepared frozen concentrate—to avoid contamination with peel oil, usually obviates any reaction.

With postmortem studies showing evidence of scurvy ten times as frequently as it was observed clinically, more than ever it is apparent that children must be guarded vitamin C-wise to insure adequate growth and development.

FLORIDA CITRUS COMMISSION • LAKELAND, FLORIDA

FLORIDA *Citrus*

ORANGES • GRAPEFRUIT • TANGERINES

The medical society's solution was to consult with local insurance agents, then to print a standard form [*see cut*] for its members' use. The form authorizes an insurance company to pay benefits directly to the doctor. It's signed by the patient at the time treatment is begun. When mailed in to the company, along with the doctor's itemized bill, the form ensures prompt payment to the right party.

Today most Phoenix doctors use this free form, and the insurance money intended for them no longer burns a hole in patients' pockets.

Need an Aide?

Office aides recruited and trained. When Phoenix felt the pinch of the secretarial shortage, the medical society promptly set up its own employment service. Aim: to save time and trouble for doctors who needed new aides. Via newspaper want-ads, and with the help of the state employment service, the society has placed fifty secretaries in medical offices during the past year. This fall, the society is starting a new briefing program for qualified applicants. Purpose: to shorten the "break-in" period and thus to lighten the load on M.D. employers.

Look Out for Frauds

Doctors protected against solicitation frauds. Phoenix M.D.'s are urged to report suspicious charity appeals *before* they give their money away. When complaints are received, Fred Mitten and his staff check into them with local authorities. The result may be public warnings like this one: "Watch out for John Doe, a solicitor making charity collections which are not authorized by either the Phoenix Solicitations Group or the Better Business Bureau. Funds are alleged to be for a kids' Christmas party and for sick veterans."

Recently, a telephone solicitor told doctors who wouldn't buy tickets for an alleged union benefit that their names would be "posted on our bulletin board, so union members will know who their friends

ORDER FOR DIRECT PAYMENT FOR SERVICES OF PHYSICIAN

Insurance Co. Zenith Insurance Company Date October 20, 19 52

Street 937 W. 23rd Street

City, State New York 11, New York

Please pay to Benjamin F. Rush a legally qualified physician and surgeon, upon

receipt of his statement for services rendered to Mrs. Mary Jones
NAME

out of indemnity due me under and in accordance with the terms of policy No. 055-74-2436 issued by your Company. Said policy was in full force and effect at the time said services were rendered. Payment of said amount as herein directed, in whole or part, shall be the same as if paid to me.

Insured Mrs. Mary Jones

Street & No. 100 North Street

City, State Phoenix, Arizona

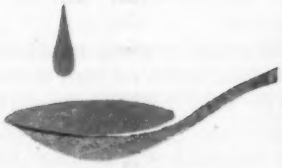
ITEMIZED STATEMENT MUST ACCOMPANY THIS ORDER. (If Insured is a minor, Order must be signed by parent or guardian.)

2 highly effective oral dosage forms

BICILLIN*

BENZETHACIL
DIBENZYLETHYLENEDIAMINE DIPENICILLIN G

- Extremely well tolerated
- Supplied ready for use
- Free from unpleasant penicillin taste
- Stable without refrigeration
- Dosage schedules need not be influenced by meal times



ORAL SUSPENSION

BICILLIN

. . . is unusually effective and palatable; ideal for use where flexibility of dosage is desired, as in pediatric practice.

Supplied: bottles of 2 fl. oz., containing 300,000 units per teaspoonful (5 cc.)

TABLETS

BICILLIN *L-A*

. . . provide *continuous* oral therapy on only 2 tablets a day, spaced 12 hours apart.

Supplied: bottles of 36 pink, grooved tablets of 200,000 units each

Wyeth®

*Trademark

are." The medical society promptly got local labor leaders to disavow such tactics. And it reminded Phoenix doctors: "The best rule is not to buy *any* tickets over the phone."

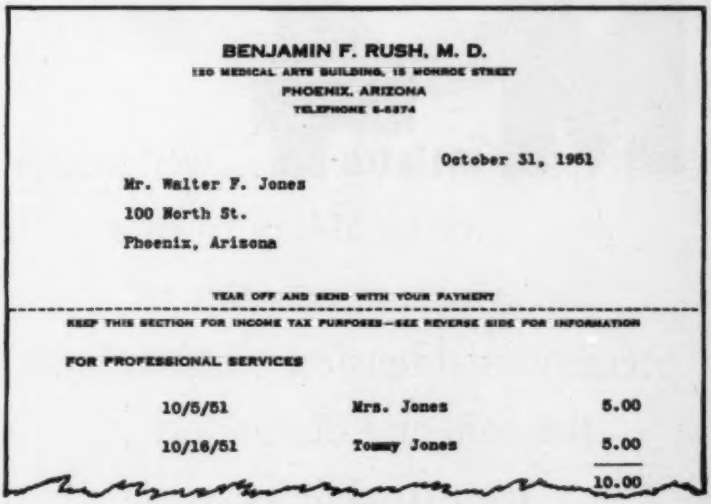
In the case of established local drives—Red Cross, Y.M.C.A., and such—the society takes a hand in setting realistic quotas, then solicits the doctors by mail. The first time this was tried (for the Red Feather community fund) the doctors actually upped their quota, then became the first group in Phoenix to reach it.

Advice on Deductions

New billing forms designed. Many people who come to Phoenix for their health run up large medical bills. Such expenses often qualify as an income-tax deduction—if the patient has an itemized receipt to show for them. Providing such receipts had become a major bookkeeping chore in some medical offices.

So the medical society distributed a new billing form [*see cut*]. Used by many Phoenix doctors today, it saves them paperwork and question-answering time. The patient tears off the top half of the statement and returns it with his remittance. The bottom half provides him with an itemized record for income-tax purposes—and also (on the back) a printed summary of the medical-deduction rules.

Prescription troubles reduced. Over-the-counter prescribing by pharmacists had been keeping some patients away from doctors. But



BENJAMIN F. RUSH, M. D.
120 MEDICAL ARTS BUILDING, 15 MONROE STREET
PHOENIX, ARIZONA
TELEPHONE 5-6574

October 31, 1951

Mr. Walter F. Jones
100 North St.
Phoenix, Arizona

TEAR OFF AND SEND WITH YOUR PAYMENT

KEEP THIS SECTION FOR INCOME TAX PURPOSES—SEE REVERSE SIDE FOR INFORMATION

FOR PROFESSIONAL SERVICES

10/5/51	Mrs. Jones	5.00
10/16/51	Tommy Jones	5.00
		10.00

When the patient complains of menstrual distress

...well known for its ability to ease the symptom-complex of premenstrual tension...also allays the pain and discomfort of menstrual distress.

PREMENSTRUAL TENSION AND DYSMENORRHEA

- headache... backache... malaise
- nervousness... irritability
- abdominal distention
- breast tenderness

A combination of clinically sound anti-edema and analgesia agents, M-Minus 4—

relieves abdomino-pelvic swelling and headache by releasing excess tissue fluids

provides analgesia for the cramps and psychic disturbances often accompanying menstruation

M-Minus 4 contains:
N, N-Dimethyl-N'-(2-pyridyl)-N'-(p-methoxybenzyl) ethylenediamine 8-bromotheophyllinate [Pyrabrom].....50 mg.
Acetophenetidin.....100 mg.
—Bottles of 24 and 100 tablets.

Whittier
LABORATORIES
Chicago 11, Illinois
A DIVISION OF NUTRITION RESEARCH LABORATORIES, INC.

Arthralgen

arthralgesic unguent—relieves joint and muscle pain, increases blood flow in rheumatic and muscular disorders, aids in the local treatment of arthritis.

Combines the 3-way synergistic action of (1) Vasodilation (Methacholine chloride* 0.25%) (2) Rubefaction (Thymol 1%) and (3) Analgesia (Menthol 10% and Methyl Salicylate 15%) in a highly absorbable ointment base.

the pharmacists had a gripe, too: M.D.'s were giving their patients rough estimates of what various prescriptions would cost; and when the actual cost exceeded these estimates, patients blamed the pharmacist.

The medical society helped clear up both situations. It got the local pharmacists to agree that they'd stop impromptu prescribing. And it got local physicians in the habit of checking with the pharmacist before quoting prices. (If a doctor thinks a pharmacist's prices are too high, however, the medical society takes up the matter with the local pharmacists' group—often with successful results.)

Tips For Doctors

Members kept well-informed. The lively bulletin, Recap, that Phoenix physicians receive every month at their homes (to permit leisurely reading) contains little routine medical news. Instead, Recap concentrates on helpful tips for their practices. In many cases, Editor Mitten's aim is to help readers profit from other doctors' mistakes. Included, for example, are:

1. Detailed reports on each case handled by the Phoenix grievance committee, with only the names omitted.

2. A "Better Left Unsaid" department, quoting double-edged remarks reportedly made by local doctors to patients. ("Why in the world did Dr. Doe prescribe . . . . . .? It's completely worthless for your illness.")

3. Reprints of lay press stories, many of them about unethical practices that have landed doctors in trouble.

Doctors' achievements kept before public. At the time Fred Mitten was hired, the community attitude toward doctors was not wholly favorable. Some civic leaders, for example, regarded the profession as "the hard, insoluble core in the community—selfish, uncooperative, and almost entirely lacking in community spirit."

To help counter this notion, Mitten first questionnaired every doctor in town. His findings: Phoenix doctors gave time and money to 274 civic, charitable, and fraternal organizations; they gave free medical service worth $250,000 a year. Once these facts were publicized, there was a noticeable upswing in community support.

Good Works Pay Off

So it was, too, with each subsequent phase of the doctors' public service program. As the facts about it became known, people stopped thinking of the local profession as "uncooperative" or "self-centered." Here are three cases in point:

¶ Reckless ambulance drivers had long been the bane of Phoenix traffic. Following a series of ambulance accidents, the doctors asked city authorities to crack down. As a result of their campaign, an ambulance ride became less hazardous for patients and the whole service was improved. Commented the local

Eliminate the needle!

Sharp & Dohme

PENALEV®, Soluble Tablets Crystalline Potassium Penicillin G, dissolve promptly in liquids—particularly useful for administration to infants with regular bottle feedings. PENALEV Tablets obviate the discomfort resulting from injection therapy and the difficulty encountered in administering large, hard-to-swallow penicillin tablets currently in use. PENALEV Tablets are supplied in packages of 12, 24 and 100 (50,000 units), packages of 12 and 100 (100,000 units), and in packages of 12 (250,000 units). Sharp & Dohme, Philadelphia 1, Pennsylvania.

PENALEV®

Soluble Tablets Crystalline Potassium Penicillin G

newspaper: "Everyone should be grateful."

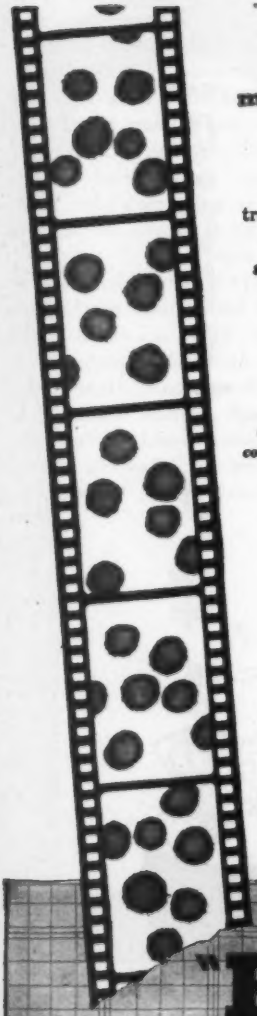
¶ Newspaper exposés of "political influence" in Maricopa County Hospital, the state's largest, had made patients reluctant to enter for treatment. So medical society officers pitched in to restore confidence in the hospital. They helped strengthen the staff, then got the local newspaper to change its tune. A short time later, the hospital received A.M.A. approval—something it had sought for five years.

¶ When "Suffer No More" drug ads appeared in the local newspaper, Phoenix doctors protested. Eventual result: The paper agreed to reject future ads for cure-all nostrums. At the same time, the pharmacists were persuaded to remove objectionable products from their shelves.

Who gets credit for this astonishing spate of activity? According to Executive Secretary Mitten, "credit for any accomplishment goes to the society's officers. The secretary is a hired hand." But Phoenix doctors are pretty sure that their hired hand has had a lot to do with the benefits they now enjoy.

Whoever's responsible, Phoenix today is a better place in which to practice medicine. It's also a better place in which to be a patient. For —as the doctors have discovered— even though medical society projects are often based on "enlightened self-interest," they can add up to a topnotch public service program. END

"I want to ask you a question for a friend of mine that has been going with a fellow."



more than iron alone

...may be needed to accelerate recovery in microcytic hypochromic anemia. This is particularly true when the anemia is the result of blood loss. In such cases, you will want to prescribe **not only iron but all the elements known to be essential for the development and maturation of red blood cells.** "Bemotinic" provides all these factors.

Each capsule contains:		
	Ferrous sulfate exsic. (3 gr.) . .	200.0 mg.
	Vitamin B_{12} U.S.P. (crystalline) .	10.0 mcg.
	Gastric mucosa (dried)	100.0 mg.
	Desiccated liver substance, N.F. . .	100.0 mg.
	Folic acid	0.67 mg.
	Thiamine HCl (B_1)	10.0 mg.
	Vitamin C (ascorbic acid)	50.0 mg.

In macrocytic hyperchromic anemias, "Bemotinic" will provide additional support to specific therapy, or may be used for maintenance once remission has been achieved. In many pernicious anemia patients there is a need for iron because of a co-existent iron deficiency.

Suggested Dosage: One or 2 capsules (preferably taken after meals) three times daily or as indicated.

No. 340—Supplied in bottles of 100 and 1,000

for just the right shade of red

"Bemotinic"

CAPSULES

Ayerst

Ayerst, McKenna & Harrison Limited
New York, N. Y. • Montreal, Canada

824

Make the most of:

Your Professional Tax Deductions

● There's truth in the old saw that a man is only as rich as his tax deductions make him. So your professional tax deductions are at least one good approach to a comfortable bank balance come March 15.

Keep the checklist below at your elbow while making out your 1952 Federal tax return. It shows all the important deductions that the Bureau of Internal Revenue allows doctors in private practice. (In nearly all cases, these should of course be listed on Schedule C.*)

The checklist will help remind you of items you might otherwise forget. And it can serve as a final check when you're ready to mail your return.

☐ ACCOUNTING: Amounts paid for bookkeeping, preparation of tax returns and estimates, and general auditing of books.

☐ AUTOMOBILE: Full operating cost if automobile is used only for professional calls or if other use is inconsequential. No part of cost if use is solely for transportation between home and office. Proportionate cost if part of use is nonprofessional. When permitted as a business deduction, auto upkeep includes chauffeur's salary and uniform; depreciation; repairs; tolls; towing; garage rent; gasoline; oil; insurance premiums (fire, theft, collision, liability, etc.); lubrication; license fees; loss or damage not covered by insurance; loss on actual sale of automobile, with depreciation considered; tires and tire repair; automobile inspection fees; parking charges; and auto club dues.

☐ BAD DEBTS: Arising from business loans or services performed, but only if previously reported as income.

☐ CLUBS: Dues and expenses if they are necessary for maintaining your business or professional con-

*Remember, too, that elsewhere on Form 1040 you can deduct a number of non-professional expenses as well. Among them may be casualty losses; maintenance of rented-out property; losses from asset sales; interest payments; and many state and local taxes (real estate, income, personal property, sales, cigarette, and—in some states—gas and liquor taxes).

By John C. Post and Peter S. Nagan

**Mr. Post is a professional management consultant in Washington, D.C. Mr. Nagan is* MEDICAL ECONOMICS' *Washington correspondent.*

Turning special diet patients into good patients

The tempting variety of the many Gerber's Strained and Junior (Chopped) Foods . . . plus the extra appetite-appeal of Gerber's special-diet recipes—these help your patients to be faithful to your diet specifications.

And of course you can count on Gerber's for the careful processing that results not just in high nutritive values, but also in low crude fiber content, bland seasoning, fine texture . . . all of primary importance for easy digestibility.

DINNER MENU

(based on recipes from Gerber's "Special Diet" booklet)

Tomato-Vegetable Cocktail (p. 14)

Meat Patties* (p. 23)

Baked Potato and Vegetable Special (p. 22)

Plum Sherbet (p. 38)

* * *

***MEAT PATTIES**

1 can Gerber's Junior Beef or Veal
2 Tbs. Gerber's Cereal
1 Tbs. milk
1 Tbs. melted butter or margarine
Additional Cereal for rolling

Mix meat, cereal, and milk. Shape into two cakes. Roll in cereal; brush lightly with melted butter or margarine. Bake on greased pan in hot oven (400° F.) until lightly browned.

FOR YOUR FREE COPIES of Gerber's "Special Diet Recipes"—based on Bland, Soft, Mechanically Soft, Liquid, and Low-Residue Diets—write on your letterhead to Dept. 2212-2, Fremont, Michigan.

Gerber's
BABY FOODS

4 CEREALS • 50 STRAINED & JUNIOR MEATS, VEGETABLES, FRUITS, DESSERTS

tacts. These include payments to service clubs and chambers of commerce if such membership is intended to benefit you in a professional way. (Itemize amounts, and name organizations.)

☐ COLLECTIONS: Expenses incurred in collecting professional accounts; attorneys' fees are included.

☐ CONTRIBUTIONS: Amounts (up to 20 per cent of adjusted gross income) given to charitable, educational, literary, religious, scientific, and other organizations that operate in a manner prescribed by law. To be deductible, contributions need not be made in cash. If property or securities are given, deduct their market value.

☐ CONVENTIONS: Cost of transportation to and from meetings; cost of rooms, meals, phone calls, tips, and such.

☐ CREDIT BUREAU FEES

☐ DEPRECIATION: On all your professional property, including automobile, instruments, books, equipment, furniture and fixtures, or any other asset having a useful life of more than a year.

☐ ENTERTAINMENT: Meals, drinks, theatre tickets, admission to games, transportation, and other entertainment costs *if* they are "ordinary" and "necessary" to your practice.

☐ EQUIPMENT: Books, instruments, and equipment used in your professonal work and having a useful life estimated at one year or less; also rental of equipment necessary to practice.

☐ GIFTS: If ordinary and necessary to your practice, and if their benefit can be proved (see also Entertainment).

☐ INSURANCE: Premiums on policies in connection with your profession, covering accident, burglary, public liability, fire, storm, theft, or malpractice; also indemnity bonds on office employes.

☐ INTEREST: On practice-connected loans and mortgages. Interest on installment contracts is deductible only if it appears as a separate item.

☐ JOURNALS AND BOOKS: If estimated to have a useful life of one year or less. Most medical journals and books are considered to be in

DOUBLES THE POWER TO RESIST FOOD

Obocell . . . an effective therapeutic substitute for will power . . . suppresses bulk (hollow) hunger and curbs the appetite. Obocell also produces a feeling of well-being, thus combating the fatigue and irritability commonly encountered when food is restricted. Patients on Obocell therapy eat less, do not violate their diet, lose weight, and are satisfied and happy. Obocell LIQUID is also available for patients who prefer liquid medication.

Obocell®

A COMBINED HUNGER AND APPETITE DEPRESSANT

Each Obocell tablet contains Dextro-Amphetamine Phosphate, 5mg.; Nicel, 150 mg. (Nicel is Irwin-Neisler's brand of high-viscosity methylcellulose).

IRWIN, NEISLER & COMPANY • DECATUR, ILLINOIS

Research to Serve Your Practice

this category. Cost is one determinant. For example, a set of books costing $100 probably would not be allowed as current expenses. But yearly depreciation on such books would be allowed as a tax deduction.

☐ LEGAL: Litigation expenses in connection with your practice.

☐ LICENSES: Physician's annual license fee.

☐ LOSSES: Losses not covered by insurance (or in excess of insurance collected) that result from property damage caused by fire or acts of nature; damages paid as a result of civil suits against you; business bad debts; theft losses; damage to your automobile.

☐ MAINTENANCE: Full maintenance cost of building used entirely as your office (proportionate cost if part of property is used for office, part for home). Maintenance includes such items as heat, light, water; repairs, painting, decorating; wages paid to janitors and elevator men; payroll taxes; and depreciation.

☐ MEDICAL SOCIETY DUES

☐ MOVING: Such expenses if in connection with your practice.

☐ RENT: If paid for professional equipment or office quarters. If only part of residence is used for business purposes, only a proportionate part of the rent is deductible.

☐ REPAIRS: Repairs to your office, including costs of decorating, painting, patching, alteration (other than permanent improvement); putting property in safe and efficient operating condition; new surfacing; repairs to roofs; repairs necessitated by a casualty, such as explosion, fire, or hurricane (not including capital restoration). Also covered are repairs to medical and business equipment.

☐ SALARIES: Paid to secretaries, assistants, substitutes, and other professional aides and consultants. Also the Social Security taxes (not employe's share) paid on such salaries. If an employe devotes only part of his full services to your professional establishment, deduct a proportionate part of his wage.

☐ SUPPLIES, MEDICAL: Dressings, vaccines, drugs, etc. consumed dur-

"She's stopped talking. She must be dead."

For Vaginal Tract Infections

AVC IMPROVED
(Allantamide VAGINAL CREAM)

In
TRICHOMONIASIS
MONILIASIS
MIXED INFECTIONS

AVC Improved is a time tested formula for the treatment and prophylaxis of vaginal tract infections.

QUICK RELIEF - EASILY APPLIED - NON IRRITATING

TRICHOMONICIDAL
It Kills Trichomonas

FUNGICIDAL
It Kills Fungi
Especially monilia.

BACTERICIDAL
It Kills Bacteria
Especially certain gram-positive and gram-negative cocci and bacilli.

DEODORANT
It Kills Odors—
Especially objectionable and unpleasant odors.

Because . . .
AVC Improved re-establishes the normal flora and the normal pH.

Because . . .
AVC Improved is indicated in a wide range of infections of the exocervix, vagina and vulva:

- *Trichomoniasis*
- *Moniliasis*
- *Specific and non-specific bacterial infections*
- *Mixed infections.*

Because . . .
AVC Improved suppresses secondary invaders . . . an important therapeutic goal.

IT WORKS!!!

Use AVC Improved in your most stubborn cases. The results will please you, and your patients will be grateful.

Formula: **9-Aminoacridine Hydrochloride 0.2%, Sulfanilamide 15%, Allantoin 2%, specially prepared buffered water-miscible base.**

Available: **In 4 ounce tubes, with or without applicator.**

Literature supplied on request.

THE NATIONAL DRUG COMPANY
PHILADELPHIA 44 PENNSYLVANIA
More Than Half a Century of Service to the Medical Profession

ing the year. (See also Equipment.)

☐ SUPPLIES, OFFICE: If used in your practice, including bills, cards, and envelopes; labels, letterheads, and printed forms; ink; postage.

☐ TAXES: If incurred in the production or collection of income. Under these conditions only, you may deduct taxes on admissions; bond transfer stamps; taxes on cable messages; customs and import duties; deed stamps; taxes on dues, on initiation fees, on property transportation, on radio messages, on safe deposit boxes, stock transfer stamps; taxes on telephone and telegraph messages, on local telephone service, on transportation of persons, on wire and equipment services.

☐ TELEPHONE AND TELEGRAPH: Such costs if incurred professionally.

☐ TRAVEL: Expenses of going to conventions affecting your practice, including baggage transfers, lodgings, meals, railroad fares, plane fares, boat fares, bus fares, telegrams, tips.

☐ UNIFORMS: Purchase price and laundering costs, on the theory that the uniforms are required by custom or for reasons of cleanliness. Such uniforms must not be suitable for ordinary wear. END

The Surgeon to His Virgeon

O darling, when cutting out tonsillar tissue,
I love you, I need you, I want you, I missue.

I think, as I patch up a bad duodenum,
If others are prettier, I've never seenum.

Here in the thick of a dull laparotomy,
Sweetie, I pray that you think quite a lotomy.

Tying the sutures for someone's colostomy,
I'm yours forever, whatever the costomy.

Even when doing a simple mastectomy,
Dearest, I vow to be what you'd expectomy.

But jealousy grips me, removing a kidney:
That guy took you all the way home again, didney?

And now that I'm doing a thoracentesis,
My heart is quite broken; who'll pick up the pesis?

Thus thoughts of you crowd me at all operations—
Which may be the reason I'm losing my pations.

—EMILY BARNHART

it's the *healing* influence

of **cod liver oil**

that makes the great difference in

DESITIN®

hemorrhoidal

SUPPOSITORIES

the hemorrhoidal patient may sit, move and walk in greater comfort as Desitin Hemorrhoidal Suppositories with Cod Liver Oil act promptly to...

- **relieve pain and itching**
- **minimize bleeding**
- **reduce congestion**
- **guard against trauma**
- **promote healing** by virtue of their contents of high grade crude Norwegian cod liver oil, rich in vitamins A and D and unsaturated fatty acids (in proper ratio for maximum efficacy).

Prescribe Desitin Hemorrhoidal Suppositories in hemorrhoids (non-surgical), pruritus ani, uncomplicated cryptitis, papillitis, and proctitis.

Composition: crude Norwegian cod liver oil, lanolin, zinc oxide, bismuth subgallate, balsam peru, cocoa butter base. No narcotic or anesthetic drugs to mask rectal disease. Boxes of 12 foil-wrapped suppositories.

Send for **samples**

DESITIN CHEMICAL COMPANY ●

70 Ship Street • Providence 2, R. I.

Letters to a Doctor's Secretary

She'll have few collection troubles if she's kindly, methodical—and firm

● Dear Mary:

In my last letter, I discussed the proper psychological approach to collections. Now I want to talk about the routine you can follow for actually bringing in the payments. The mechanics of collecting is a big subject, so let's relax and go over it slowly, point by point.

First, let me remind you to make a habit of collecting all small fees at the time the service is rendered. Always have your receipt book ready on your desk during office hours. Most patients will ask you as they go out, "How much do I owe you?" or "Shall I pay now?" Answer pleasantly, open your receipt book, and start to write a receipt. This discourages the "charge it" impulse.

If the patient starts to leave without saying anything about payment, detain him with some courteous remark. For example: "Shall we be seeing you again soon?" or "Are you to have another appointment?" As he pauses to answer, open your receipt book, poise your pen, look him calmly in the eye, and say, with a smile, "The charge for your call today is $5." Sometimes, of course, this procedure would be inappropriate; but if so, Dr. Barrie will let you know ahead of time.

For larger bills, you send out statements toward the end of each month—an activity I covered in an earlier letter. In a perfect world, that's all you'd ever need to do. But you have learned by now that not all patients pay promptly. Some of them require a good deal of coaxing—and a few never pay at all.

There are many different methods for tackling collections, but here's the most effective one I've found: When you've billed a patient for two months without response, write a little note on the first of the third month. Don't make a notation

---

By Anna Davis Hunt

**These letters were published originally as a series in* MEDICAL ECONOMICS, *signed with the nom de plume Myrna Chase. In response to a great many requests, they are being reprinted in revised and updated form. The complete current series, of which the present letter is the fourteenth, is now available as a book.*

on the statement itself. Instead use a separate sheet of paper, smaller than the statement. A small white scratch pad of heavy quality will do. At the top of this sheet type the word "NOTICE." Below that, say, "This account is past due. Your attention is courteously requested." The "courteously" may seem superfluous; but it's indispensable, believe me.

Now clip the notice to the statement and mail it out. Often, it will bring in the payment.

Second Notice

Should the patient not respond within two weeks, send another statement, with this notice: "Again calling attention to your account, which is now very much past due. Please let us have your remittance without further delay." You're still being polite; but this second notice has an element of urgency.

Ten days later, if there's been no answer, send the following letter:

> So far no advice has been received regarding your account of $——for professional services rendered you last March. If it is impossible for you to settle in full at this time, it will be appreciated if you will inform us of your expectations.
>
> In anticipation of your kind consideration, I am,
>
> Sincerely yours,

This may sound ponderous and pompous, but it's psychologically sound. It contains no hint of blame, you see. "You" and "yours" are used six times and "us" and "I" only once each—a most effective device. The words are long, the implications flattering. The letter should impress the patient without arousing his stubbornness. Chances are, it will bring results, when a chatty, personal, or slightly censorious letter wouldn't.

Whenever you receive a note of apology with a promise to pay at some future date, be certain to answer it right away. If you do, the patient will realize the importance you attach to his note; and he'll probably try to live up to his promise.

Are you beginning to tire of all these follow-ups? Better take an aspirin and buck up, then, for your real work may just have begun.

The Phone Approach

If correspondence by mail hasn't brought results, your best bet is to telephone. Keep up an intensive telephone campaign for at least a month before you take the final step —that is, before you begin to threaten.

No matter when you call, ask, "Is this Mrs. Smith?" in such a pleasant manner that she replies as if some old friend were calling her. Then, when you've told her who you are, asked her how she is, and proceeded to get down to business, it'll be hard for her to be sullen or belligerent. I used to say something like this:

"You know, I'm Dr. Barrie's bookkeeper. I see I've already allowed

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VC-5000 PORTABLE SHORT WAVE DIATHERMY UNIT

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Despite its ready portability, this rugged, ACMI-engineered short wave diathermy unit gives peak performance for optimal deep heat therapy or precise electrosurgery. High power output, conveniently and safely controlled, permits unusual flexibility.

For diathermy, condenser applicator pads and/or cuffs, or the inductance cable, may be easily adjusted to body contours without tapes or straps.

For electrosurgery, using orificial or surgical electrodes, the high frequency current may be controlled with hairline precision for any hemostatic cutting, from the most delicate incision to mass excisions in bloody fields.

Model VC-5000 is handsomely encased in a sturdy, all-steel cabinet with lasting scratch- and crack-proof enamel finish.

Standard accessories: 1 Inlet cable; 2 heavy rubber condenser pads, 7" x 10"; 1 inductance cable; and 4 heavy, perforated felt spacers, 8"x11".

Size of unit: approx. 15" high, 14" wide, 17" deep.

Write for descriptive literature

American Cystoscope Makers, Inc.

1241 LAFAYETTE AVENUE — FREDERICK J. WALLACE, President — NEW YORK 59, N. Y.

more time than I should on your account of last June. I'm calling to ask when I may expect a settlement."

Your tone of voice is everything. Imagine that you're asking an old friend why she hasn't been to see you. Always be polite and sympathetic—but always be firm.

You'll unearth a lot from these telephone conversations. You'll learn of dissatisfactions, real or pretended; all sorts of excuses will be given you, some of them sincere and satisfactory—like a new baby or a husband out of work. In cases where leniency is justified, be exceptionally kind and considerate. But beware of patients who put you off too pleasantly, with an easy promise of payment next week; if they're *too* facile, they're likely to be expert deadbeats.

Set a Date

Try to get the patient to set a definite date or dates for payment. Then drop him a follow-up letter reading something like this: "In accordance with our telephone conversation this afternoon, I look forward to receiving payment of your outstanding account ($——) on or before [the exact date, whatever it is]." Putting the agreement in black and white fixes it more firmly in the patient's mind.

Call him again each day that one of his promises falls due. Here enters the psychology of dunning: Incessant bombardment will wear out the most obstinate debtor.

Of course, in the case of an out-of-town patient or one with no telephone, you'll have to use a series of letters; but the principle is the same. Try to make your letters as forceful (but polite) as possible. All collection letters should be signed by you, not by the doctor. And never say that the doctor *needs* the money. This has nothing to do with a patient's indebtedness.

Time for a Threat

If your energetic reminding goes on for four to six weeks with only broken promises to show for it, proceed to the next step: a dignified, almost sorrowful letter threatening to turn the account over to a collector. This letter is always sent by registered mail with a return receipt requested. Here is the form I prefer:

> We have received no remittance on your account of $——, dating back to ——, despite repeated requests for payment. We are sorry to have to inform you, therefore, that we can no longer carry the account on our books.
>
> Unless we hear from you by [a specific date], we shall be obliged to turn your account over to the ———Credit Bureau for collection, without further notice. This will reflect on your credit standing locally and will mean added expense for both of us. So we sincerely trust it will not become necessary.

Such a letter will bring a response from nearly all who are not dishonest or irresponsible. Allow three ex-

tra days of grace to those who fail to respond; then give the account to a collector. If the patient comes howling, simply say that the matter is now entirely out of your hands. Never make idle threats. Always keep your promises.

A word of warning: Because most accounts that reach your collector are those of unscrupulous and dishonest persons, never turn over a large account until the statute of limitations for filing malpractice claims has expired. The unscrupulous patient may be tempted, you see, to file a countersuit; but the law allows him to bring suit only within a limited period after the doctor has treated him. (Determine what that time limit now is in your state; it differs among the states.)

A Card a Day

Perhaps at this point you're wondering, "How under the sun am I to keep track of whom to call about overdue bills, and when?" And a most important question it is. But there's an easy answer to it: the follow-up file.

This consists of a card-file box that contains 365 tab cards, each marked for a day of the year. Here's how to use it:

Bills are made out from the patients' ledger cards. These cards,

"Well, it's just that I haven't been myself lately—and I'd like to keep it that way."

of prime importance
— THE RELIEF OF PAIN

"There is little doubt that, when analgesics are employed on a rational basis, physicians will come nearest to fulfilling with credit that phase of medical practice which, at least to the patient and his family, is of prime importance – the relief of pain."

Editorial: J.A.M.A. *149*:66 (May 3) 1952

NEW

prompt... prolonged...

prescribed relief of pain

APAMIDE

BRAND • TRADEMARK

tablets

(N-acetyl-p-aminophenol, 0.3 Gm.)

analgesic-antipyretic

rapid, direct analgesia

Apamide quickly relieves pain and reduces fever through direct analgesic-antipyretic action. It avoids the delay inherent in compounds that require metabolic transformation to produce analgesia.

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Apamide goes to work fast. It raises the pain threshold substantially within 30 minutes, reaches peak effect in about 2½ hours and continues to be effective for approximately 4 hours.

well-tolerated analgesic

Apamide is a pure, active agent that does not produce extraneous, possibly toxic metabolites. High dosages over long periods have not been shown to cause toxic reactions or gastric upsets. It is extremely valuable in patients who cannot tolerate salicylates.

℞ *only*

Available only on your prescription, *Apamide* permits precise control of dosage and duration of treatment *by you*. Prescribe it for relief of pain and reduction of fever in respiratory infections, functional headache, muscular or joint pain and dysmenorrhea.
Average adult dose, 1 tablet every four hours.

for a sedative-analgesic

prescribe

APROMAL

BRAND • TRADEMARK

tablets

(N-acetyl-p-aminophenol, 0.15 Gm. and acetylcarbromal, 0.15 Gm.)

non-narcotic, non-barbiturate

Apromal is especially valuable in those cases where pain coexists with tension, anxiety, restlessness, excitement, nervousness and irritability. *Apromal* contains Apamide and the widely used, gentle daytime sedative, acetylcarbromal. Enhancement of both analgesia and sedation is secured by this combination. Average adult dose, 1 tablet every 4 hours.

AMES
COMPANY, INC., ELKHART, INDIANA

Ames Company of Canada, Ltd., Toronto

41351

which I described in an earlier letter, show charges and payments made. On the left-hand side of the cards is room to jot down the date and a description of each effort at collection. For instance:

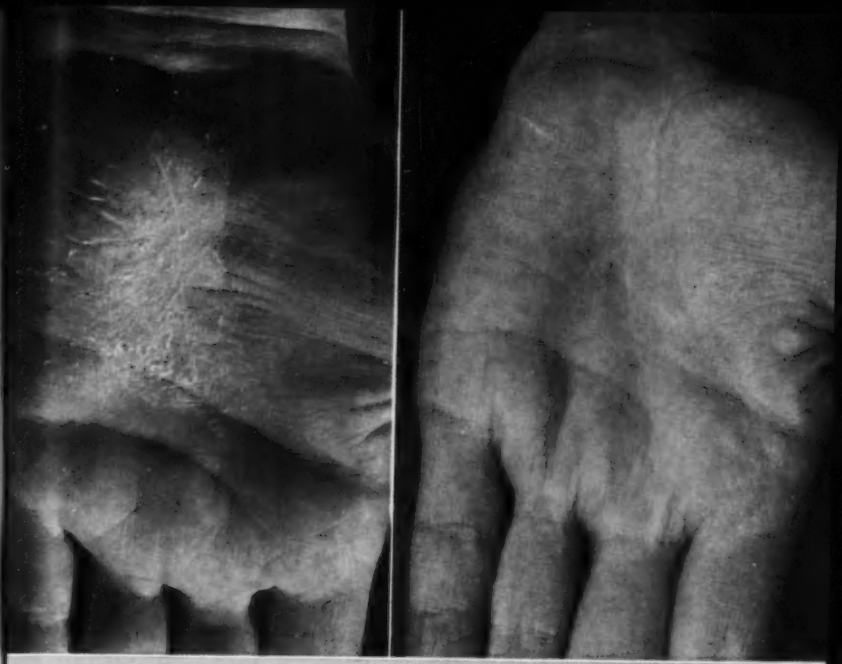
1/2/53 Notice 1
1/14/53 Notice 2
1/26/53 Letter 1
1/30/53 Phoned. Promised full payment 3/10

When you make the first of these notations on the patient's ledger card, you also write his name on a slip of paper and drop it behind the Jan. 14 card in your follow-up file. On that date, you draw out the slip, check the patient's ledger card, and, if no payment has been made, send out the second notice. You then note your action on the ledger card and place the name slip behind the Jan. 25 card in the follow-up file. And so on.

Try to scatter your follow-up dates throughout the month; you'll want to have not more than half a dozen letters or telephone calls to undertake each day. Then don't let anything interfere with them on the day scheduled. If you do, you may fall hopelessly behind, and your system will be no system at all.

Your skill in collections can be of immense value to the doctor. Since he never enters the collection picture, his patients don't think of him as concerned primarily with fees. On the other hand, if *you're* on your toes, they won't impose on him or consider him an easy mark.

As ever,
Myrna Chase



This stubborn eczematous eruption had persisted for 5 years despite treatment with many preparations and therapies.

In only 38 days with 'Pragmatar', this striking result was achieved. From the beginning of treatment itching had been relieved; scaling, checked.

for stubborn eczematous eruptions

Pragmatar*

highly effective in an unusually wide range of common skin disorders

'Pragmatar' is generally recognized as the most effective preparation available for eczematous eruptions and for many other common skin disorders. Among them: common scalp disorders and dandruff; seborrheic dermatoses; fungous infections, including "athlete's foot"; pruritus, etc.

Formula: Cetyl alcohol-coal tar distillate, 4%; near-colloidal sulfur, 3%; salicylic acid, 3%—incorporated in a special washable base.

Smith, Kline & French Laboratories, Philadelphia

*T.M. Reg. U.S. Pat. Off.

Her stoic smile

This is the fourth of a series of Norman Rockwell portraits depicting patients typical of those you see in your everyday practice.

is wearing a little thin . . .

Fatigue, fretfulness and irritability are bound to arise—even in a patient as well adjusted as this one—during the long days of discomfort and inactivity that follow physical injury. Psychic distress will complicate the period of recovery—not only for the patient herself—but also for her family and physician.

You will find 'Dexamyl' of unique value in managing the mental and emotional distress that follows physical injury. 'Dexamyl' is a balanced combination of *two* mood-ameliorating components:

1. Dexedrine* Sulfate—the antidepressant of choice—to lift the patient's mood and provide a sense of well-being.
2. Amobarbital (Lilly)—the sedative that elevates mood—to relieve nervousness, anxiety, and inner tension.

Dexamyl's two mood-ameliorating components work synergistically to provide a "normalizing" effect—free of the dulling effect of barbiturates; free of the excitation caused by stimulants.

DEXAMYL† tablets and elixir

Smith, Kline & French Laboratories, Philadelphia

Which Mutual Fund Should You Buy?

Don't base your decision solely on comparative performance statistics. They're often misleading

• "How can I judge the performance of mutual funds?" a doctor asked me recently.

He owned shares in three different mutual investment companies, he added. And he was satisfied with all of them. "But every so often a salesman tells me that the fund *he* sells has a better record than any other," he remarked. "And I've read several articles that compare the performance of mutual funds. Each *sounds* logical; yet my mutual funds may turn up at the top of one list and at the bottom of another. What am I to believe?"

I reassured the doctor on one score: He isn't the only investor confused by conflicting claims. Conservative firms in the mutual fund business realize that comparative performance studies may be misleading; so they're cautious about using them. Here's why:

In the first place, the aims and methods of mutual funds vary widely. Some are interested chiefly in capital appreciation, with little regard to current income; others put the emphasis on income. Some mutual fund managements have full discretionary power over investment policy; others operate on a fixed-formula plan.

Massachusetts Investors Trust, the largest of the funds, tries, for instance, "to limit its common stock holdings to those of high quality which will meet the standards sought by fiduciaries," with the thought that "consistent, generous income is always an important factor in security selection." On June 30, 1952, M.I.T. had 98 per cent of its funds in common stocks.

Yet on that same date, another large investment trust, Eaton & Howard Balanced Fund, had only 59 per cent of its assets in common stocks. This reflects an investment philosophy, not pessimism about the market. As a "balanced" fund, Eaton & Howard maintains a balance between common stocks, preferred stocks, and bonds.

Or take a fund with an entirely different philosophy: Growth Companies, Inc. This one places primary

---

By Raymond Trigger

**The author is the editor of Investor magazine.*

VERILOID®

BRAND OF ALKAVERVIR

treats the patient

by inducing

- **PROMPT SYMPTOMATIC RELIEF**
- **GREATER STAMINA**
- **IMPROVED SENSE OF WELL-BEING**

The patient receiving Veriloid experiences prompt relief of the very symptoms which caused him to seek professional care. Shortly after dosage adjustment is completed, headache and malaise are greatly reduced in severity or disappear entirely, and a sense of well-being quickly develops. This subjective improvement usually precedes a significant fall in blood pressure.

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Through central action, Veriloid produces a gratifying drop in arterial tension in a significant percentage of patients treated. A unique, highly purified fraction of Veratrum viride, Veriloid is indicated in all grades of essential hypertension. The average patient requires from 9 to 15 mg. daily in divided doses.

Veriloid (brand of alkavervir) is available on prescription in 1 mg., 2 mg. and 3 mg. tablets.

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emphasis on profit. So it confines its purchases largely to stocks of "companies which are working extensively in expanding fields and have found, or are aggressively seeking, new products, improved processes or added outlets."

Then there are mutual funds that put nearly all their investable assets into a single industry or type of industry. Chemical Fund and Television & Electronics Fund are two examples.

And, finally, there is the so-called "leverage" fund, whose shares are more volatile than those of other investment trusts. This type of fund's investments are such that its shares tend to rise sharply in a rising market—and to fall swiftly in a falling one. The largest company in this class is Affiliated Fund.

They're All Different

Obviously, it makes no sense to group all these types into one table or chart for the purpose of comparing performance records. By their very nature, they aren't supposed to perform alike.

But that's only half the story.

By the simple device of hand-picking the period over which a comparison is made, almost any mutual fund can "prove" top performance. And, of course, it can be shown similarly that the very same fund—or almost any other one—performed badly.

There's an interesting example of one kind of statistical gymnastics in a recent issue of the University of Chicago's Journal of Business. In an article called "Management Achievement of Open-End Investment Companies," George Wilber Moffitt analyzes the market performance of mutual funds. His article is honest; it's impartial; it's painstaking. But it's also thoroughly misleading.

Let's examine it to see why:

According to Moffitt, "the only true test of management achievement is that test which measures the achievement from a specified level of the common stock market until that same specified level is again reached." He has selected three periods that meet this specification, as measured by Standard & Poor's Composite Stock Index:

¶ Dec. 31, 1929, to Jan. 16, 1951 (twenty-one years);

¶ Sept. 16, 1936, to Sept. 13, 1949 (thirteen years);

¶ Dec. 31, 1933, to Jan. 16, 1943 (nine years).

But let's begin by asking whether the original assumption is valid. Does this type of measurement provide a good basis for rating management achievement?

I doubt it, for two reasons:

Stock Prices Rising

1. No such test period squares with the fact that the long-term trend of common stock prices in this country has been up. The annual rise has averaged about 3 per cent over the past half-century. And if the long-term trend of the stocks in which mutual funds invest is up-

ward, it hardly seems sensible to compare results for a selected period during which there was *no* long-term price change.

2. Though a stock market index moves as a unit, the stock market itself *never* does. This is a vital point for the doctor-investor to keep in mind. Let's clarify it by a few examples:

I have before me a study prepared by Standard & Poor's. It examines the so-called "Defense Program Market" extending from June, 1950, to July, 1952. During that period, the Standard & Poor's Composite Stock Index (compiled from the market prices of ninety stocks) rose nearly 44 per cent. But during that same period:

¶ Tire and rubber stocks rose 98 per cent;

¶ Oil stocks rose 88 per cent;

¶ Canadian gold stocks rose 40 per cent;

¶ Moving picture stocks *declined* 2 per cent;

¶ Tobacco stocks *declined* 12 per cent;

¶ U.S. gold stocks *declined* 20 per cent.

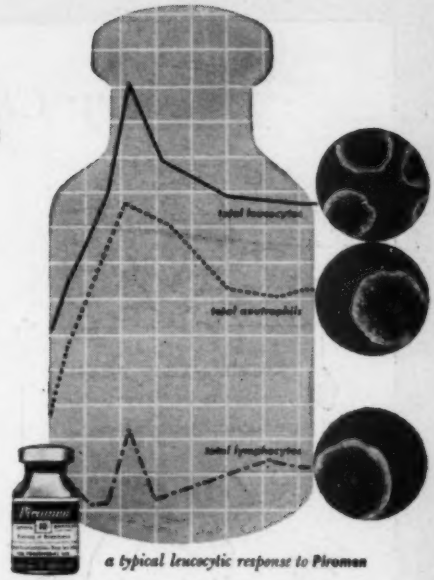
Some Up, Some Down

The same story can be told for *any* period of time. Even during the greatest bull market in history, in the late 1920's, some stocks actually declined in price (example: American Woolen). Study the financial page any day of the business week, and you'll find some stocks hitting new highs for the year while others hit new lows. [MORE→

Piromen*

(DISPERSION OF DESACCHROMIN)

for effective control of a wide variety of *ALLERGIES* and *DERMATOSES*



a typical leucocytic response to **Piromen**

Every day more physicians are discovering the early clinical benefits effected by the administration of ***Piromen***, employed either as a specific, or concomitantly with other drugs.

Piromen is a biologically-active bacterial polysaccharide which produces a marked leucocytosis and a stimulation of the reticulo-endothelial system. It is nonprotein, nonantigenic, and may be employed safely within a wide range of dosage.

Piromen is prepared in stable colloidal dispersion for parenteral use. It is supplied in 10 cc. vials containing either 4 gamma (micrograms) per cc., or 10 gamma per cc.

For a comprehensive booklet detailing the use of this new therapeutic agent, merely write "***Piromen***" on your *Rx* and mail to—

*TRADE MARK

Manufactured by

TRAVENOL LABORATORIES, INC.

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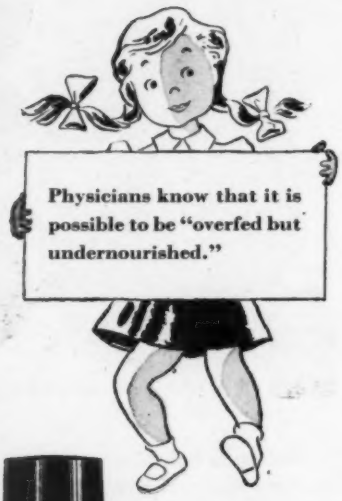
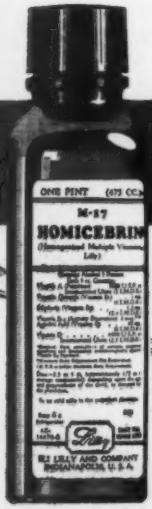
Every Child Can Be a



Lilly



Available in 60-cc., 120-cc., and 1-pint (economy) sizes.

Eli Lilly and Company, Indianapolis 6, Indiana, U.S.A.

Nutritional Prodigy

'Homicebrin'

(HOMOGENIZED MULTIPLE VITAMINS, LILLY)

That the stock market by no means behaves uniformly is ignored by many tyro investors. Yet even the indexes, which purport to show in what direction the market moves, may not agree.

Take the period from Dec. 31, 1929, to Jan. 16, 1951. According to the Standard & Poor's index, the market was at the same price level on the second date as on the first. But the New York Times Combined Average showed a decline of 15 per cent during that same period!

One experienced Wall Street analyst puts it this way: "The stock market is like Diogenes: It's searching for an honest fact; and as it lifts its lantern to one statistic after another, it realizes that no statistic is entirely honest."

Nine Funds Compared

As a case in point, consider one of the periods studied by Moffitt. For the thirteen years between Sept. 16, 1936, and Sept. 13, 1949, he summarizes his findings for nine mutual funds thus:

Name of Fund	Average Annual Change in Asset Value*
Loomis-Sayles Mutual	+3.31%
National Investors	+2.91
State Street Investment	+2.01
Century Shares Trust	+1.71
Broad Street Investing	+0.94
General Capital	+0.84
Wellington Fund	+0.81
Incorporated Investors	+0.51
Mass. Investors Trust	−0.35

Now, one thing wrong with this grouping is the fact that these nine mutual funds have widely varied *objectives*. One fund (Century Shares Trust) invests solely in bank and insurance stocks. Another (Wellington Fund) maintains a balanced portfolio. Still another one (National Investors) concentrates solely on growth stocks. And several of the common stock funds go all out for capital appreciation, let the income fall where it may. [MORE→

*Including disbursements.

Nothing but the Best

● A G.P. friend of mine told a locally prominent matron that her son needed a tonsillectomy. Too snobbish to have the operation done in the small town where they lived, the mother took the boy to a specialist at a distant medical center.

Some time later, the G.P. saw the mother on the street. She halted him and exclaimed triumphantly: "Oh, Doctor, we're *so* happy Richard was under that specialist's care when he had the operation—because he *almost* bled to death!"

—FRED Z. HAVENS JR., M.D.

But let's focus on another thing wrong with this table: its apparent demonstration that Massachusetts Investors Trust had the poorest record of all, while Loomis-Sayles Mutual had the best.

How It's Figured

Let's see what happens when—for a similar period, and with the same available facts—the statistics are somewhat differently presented.

Let's go back fifteen years and make comparisons not only for the entire period (using year-ends—from Dec. 31 to Dec. 31) but also for parts of the period, dropping off one year at a time. In this comparison, we'll take the "best" and the "poorest" in the previous table—i.e., Loomis-Sayles Mutual and Massachusetts Investors Trust:

Period	No. of Years	Change in Asset Value* Loomis-Sayles	Mass. Investors
1936-51	15	+ 79.4%	+ 98.6%
1937-51	14	+146.9	+201.7
1938-51	13	+120.2	+149.1
1939-51	12	+129.5	+160.1
1940-51	11	+155.4	+196.3
1941-51	10	+176.9	+237.9
1942-51	9	+140.8	+206.2
1943-51	8	+104.6	+151.7
1944-51	7	+ 80.3	+113.3
1945-51	6	+ 34.2	+ 64.9
1946-51	5	+ 38.5	+ 79.0
1947-51	4	+ 44.9	+ 78.8
1948-51	3	+ 44.6	+ 81.0
1949-51	2	+ 27.9	+ 53.7
1950-51	1	+ 14.6	+ 22.5

Thus, the performance of Massachusetts Investors Trust shows to advantage over Loomis-Sayles for the full fifteen-year period—and for every one of the subsequent periods as well. Yet the table cited earlier implied the opposite.

Both tables are honest and accurate, but the statistical *method* is different in each. In the first case, *average change per year* is tabulated; in the second, *change to the end of the period.*

Even if statistics were always dependable, past performance would be no sure key to the future. A fund whose record was tops last year won't necessarily repeat.

Best Way to Measure

But if performance figures don't always mean too much, what yardsticks *can* you use in selecting a mutual fund? Here are two:

1. Make sure that the fund you're considering meets your basic objectives. Are you interested mainly in safety, good income, or opportunity for capital gain? Does the management's aim accord with yours?

2. Make sure that the management personnel of the fund are top-grade. How well are they equipped by character and experience to manage the investment of your money?

Satisfy yourself on those two points, and you'll probably fare better than you would by puzzling over statistics of past performance. An investment dealer or broker can give you the facts about any fund's management. If he can't or won't, take your business elsewhere. END

*Including disbursements.

A Medical Center for Every Community

[CONTINUED FROM 89]

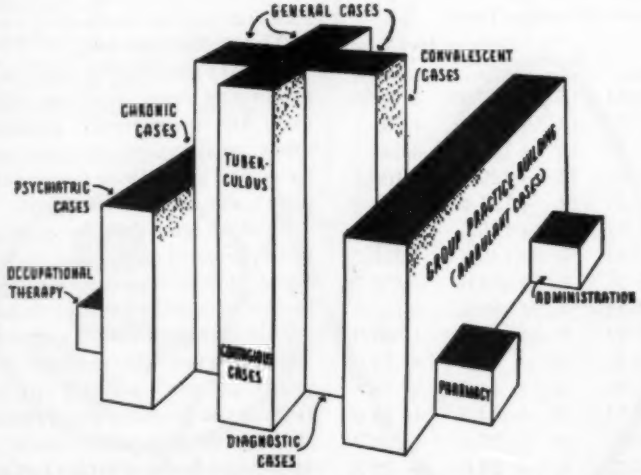
business-minded. They say, in effect: You can approach the whole problem of national health in business terms. Medicine has a product or service—medical care—to sell. But today it is being distributed inefficiently.

To remedy these shortcomings, medicine must develop into a true industry—into a decentralized big business, so to speak. And it must become a self-respecting business that pays its own way.

Where does the individual doctor fit in? A.F.M.C. officials see him "being swamped by the forces of our highly industrialized and organized society." Moreover, "While other groups . . . produce and distribute their products and services in accordance with a highly organized plan, the doctor is usually forced to work alone"—and inefficiently.

But let him work at maximum capacity—in team practice—free from financial burdens and with the best facilities, and he'll produce a superior product: namely, better medical care.

However practical and down-to-



This block drawing shows the main divisions to be included in one of the proposed community medical centers where all types of cases would be handled. The drawing is not intended to indicate arrangement or architecture.

"... one should keep in mind that OBESE persons can have vitamin deficiencies, too."[1]

Putting on and taking off weight is fundamentally a matter of adding or subtracting calories. However, if the caloric intake is low enough to accomplish weight reduction, nutritional deficiencies may appear, as well as irritability, fatigue, and mental depression so frequently caused by the restricted diet.

AMPLUS provides a simple and effective aid in the management of obesity, aimed at weight loss and prevention of nutritional deficiencies. AMPLUS combines the nutritional supplementation of 8 Vitamins and 11 Minerals and Trace Elements with the anti-depressant and appetite-inhibiting action of dextro-Amphetamine sulfate.

for sound
OBESITY management
all in one capsule

The obesity regimen shows better results when AMPLUS is prescribed.

AM PLUS

DEXTRO-AMPHETAMINE SULFATE	5 mg.
CALCIUM	242 mg.
COBALT	0.1 mg.
COPPER	1 mg.
IODINE	0.15 mg.
IRON	3.33 mg.
MANGANESE	0.33 mg.
MOLYBDENUM	0.2 mg.
MAGNESIUM	2 mg.
PHOSPHORUS	187 mg.
POTASSIUM	1.7 mg.
ZINC	0.4 mg.
VITAMIN A	5,000 U.S.P. Units
VITAMIN D	400 U.S.P. Units
THIAMINE HYDROCHLORIDE	2 mg.
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NIACINAMIDE	20 mg.
ASCORBIC ACID	37.5 mg.
CALCIUM PANTOTHENATE	3 mg.

1. Spies, T.D.; Stone, R.E.; Garcia-Lopez, G.; Lopez-Toca, R.; Reboredo, A.: Therapeutic Indications for Vitamins in Mixtures. Postgrad. Med., 10:269 (Oct.) 1951, p. 281.

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earth this analysis may sound to laymen, it's likely to raise some hackles among medical men. The latter will detect certain differences between selling refrigerators and providing individual medical care. Some may be alarmed at Dr. Norris's statement that "We'll be eliminating the fee-for-service principle." Others may side with the *minority* report of the Committee on the Costs of Medical Care, which said:

"The minority recommends that the corporate practice of medicine, financed through intermediary agencies, be vigorously and persistently opposed as being economically wasteful, inimical to . . . high quality of medical care, and unfair exploitation of the medical profession."

There's also the danger, foreseen by some doctors, that a national network of health centers might offer too much temptation to a socialist-inclined Government. By simply substituting compulsory for voluntary insurance, such a ready-made set up might be easily taken over.

Besides the reluctance of many M.D.'s to go along with the A.F.M.C. plan, there may be other practical hurdles. The estimated premium cost—say, up to $400 annually for a family of four—may prove more than a good many people can afford. Even if some companies pay part of this for their employes, what about those employes' dependents? And is it fair, or feasible, to tax all income groups at the same rate?

Apparently, the A.F.M.C. figures on basing this individual assessment on the per capita share of the nation's current outlay for all forms of health care. This is scarcely the way an actuary would figure the insurance risks in fixing an adequate premium, nor is it the way a manufacturer would set the prices of his products. It's possible that people who don't want to buy that much medical care in advance might even turn back contentedly to the solo practitioner and the fee-for-service.

What A.F.M.C. Does

But at this time, A.F.M.C.'s formulas are flexible. What it envisions on paper may not be what it will settle for after coming to grips with local doctors and laymen. And that hasn't happened yet, although several communities, the federation says, have already asked it to study their needs and to plan medical centers for them. Here are the steps that A.F.M.C. proposes to take when (and only when) it's invited into a community:

1. The field staff will first interview local medical men; representative citizens; and business, church, school, and labor leaders in order to determine medical needs and local attitudes toward group practice and health insurance.

2. If the community needs and wants a medical center program, the A.F.M.C. staff will map out a plan to finance, staff, and operate it.

3. With insurance companies, the A.F.M.C. will then work out a comprehensive prepayment policy on a community-wide basis. [MORE→

Since it acts merely as catalyst and advisor for the projects, the A.F.M.C. will *not*: (1) raise capital funds; (2) dictate building designs; or (3) select professional personnel. These jobs are up to the community; and the A.F.M.C. aims to make each medical center a self-activated, self-operated, and self-supported unit.

The self-support, of course, will derive mainly from the income of insurance benefits. How will such community insurance plans be set up? On this point, A.F.M.C. officials are not yet definite. But there will be negotiations with local employers and with unions that have welfare plans. Policies will be available to individuals and families as well as to employed groups and will have a deductible clause so that small medical bills must be paid out of pocket. As for the medically indigent, their policies will be paid for, in full or part, out of welfare funds.

To help cut the costs of serious illness and keep premium rates down, preventive medicine will play a major part in local center services. In fact, says Dr. Norris, such centers will work only if there is both insurance *and* preventive medicine. But how it's to be provided presents some difficulties. For, according to Dr. Norris, "almost no preventive medicine is practiced in this country today."

Industry's Stake

These autonomous health centers, the A.F.M.C. contends, should directly benefit three sections of the community: industry, the residents, and the doctors.

For local industry, the centers will reportedly

¶ Reduce the demands for large contributions to hospital and other medical funds.

¶ Provide medical care for employes of small plants that can't afford separate health projects of their own.

¶ Reduce absenteeism and, in turn, manufacturing costs through prompt diagnosis, equally prompt treatment, and a preventive medicine program.

The individual citizen, it's said, will be getting complete medical, dental, and hospital care at a price within his means. Moreover, with all diagnostic and specialist services available to him under one roof, he'll be less likely to indulge in doctor shopping. The centers will also draw doctors to rural areas that now lack adequate medical services.

Appeal to M.D.'s

For the physician, the A.F.M.C. foresees these advantages. The medical center set-up will

¶ Provide hospital connections for doctors who now have none.

¶ Discourage "unproductive" competition among doctors.

¶ Give the doctor more security through salaried practice and retirement plans.

¶ Bring him more time for research and postgraduate study.

¶ Give young physicians a quicker foothold in professional life and

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spare them some of the financial burden of equipping themselves for solo practice.

Privately, however, A.F.M.C. spokesmen grant that "doctor psychology" may be one of the biggest humps they'll have to surmount. They admit that their program's most powerful appeal will be to young doctors and that the established M.D. with a successful practice probably won't be enthusiastic. But the plan can succeed without him, they feel.

Which raises an interesting question: If community medical centers, drawing mostly young physicians, begin to blanket the country, as A.F.M.C.'s sponsors confidently hope they will, what will happen to the solo practitioner? Will his tribe just naturally decrease as the older doctors die off?

Another unanswered question is this: In setting up local group medical services, A.F.M.C. will need the help of all community leaders—those representing labor, business, and local government, as well as the medical, dental, and public health professions. Then, when it has done its job, A.F.M.C. will pull out, leaving the center to operate itself.

Who will be left in control? Will the doctors be able to run their own show? Or will there be too many fingers in this pie in the sky for efficient operation? END

"Ethel, I love you, Ethel! You *are* Ethel, aren't you?"

What's in the Magnuson Report?

[CONTINUED FROM 70]

Minnesota. It may take monetary help to get groups started elsewhere, the commission believes—since they usually require "a considerable initial outlay." Tentative recommendations: subsidize them at the start through government loans, and encourage them to offer their own prepayment plans.

2. REGIONAL INTEGRATION. Teamwork between local doctors isn't enough if their area lacks specialized facilities. Suppose, for example, they have to get along without laboratory and blood bank services, without pathology and electrocardiography. Such doctors are clearly limited in what they can do for patients.

Larger hospitals have such facilities, of course. But as Dr. Edwin L. Crosby reported to the commission, 69 per cent of all short-term hospitals are small ones—less than 100 beds. His recommendation (and almost certainly the commission's): Let large hospitals extend special services to small hospitals in their region, and through them to local doctors.

Two successful examples of this have strongly influenced the commission:

¶ In an eleven-county area around Rochester, N.Y., thirty hospitals have worked out their own regional plan. They share laboratory, diagnostic, and consulting services; they have joint purchasing and uniform accounting; they provide post-graduate training for doctors, nurses, and hospital personnel. "This program," says Dr. Magnuson, "seems to have improved appreciably the quality of care."

¶ In Maine and Western Massachusetts, many small hospitals have established close contact with the New England Medical Center in Boston. Their medium: the Bingham Associates plan. They get pathology and X-ray services, teaching residents, consultations with Boston specialists. Says Dr. Magnuson: "This plan is pulling rural physicians and smaller hospitals into the vortex of modern medical practice."

How can this sort of thing be encouraged? The chief needs are *organization* and *money*, according to preliminary findings.

What type of organization? A series of voluntary, autonomous regional bodies—about 150 of them, covering the whole U.S.—is envisioned. They'd represent all interested parties in their areas: doctors, hospitals, insurance plans, and the public. They'd seek to foster the extension of services from large hospitals to small ones.

It Takes Money

The main obstacle, as Dr. Magnuson sees it, is "the old bugaboo of insufficient funds. Most [existing]

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coronary disease • diabetes
hypertension • obesity
alcoholism • liver disorders

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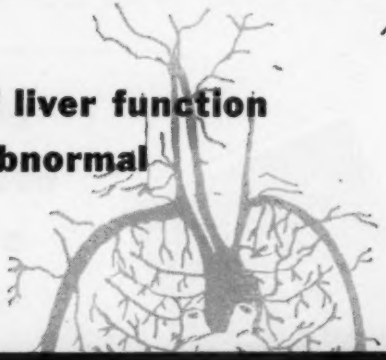

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1. Abrahamson, E. M.: Amer. J. Digest. Dis. 19:186, 1952.

2 atherosclerosis favorably influenced

"Positive results – as evidenced by profound effect on the chylomicron-lipomicron ratio" in older atherosclerotic (infarction and non-infarction) patients given Methischol. Lipotropic substances "can and do influence the lipids in human serum in the direction of apparent normality." Findings "bear out the clinical observations of a number of investigators claiming definitive effect in atherosclerotic individuals."[2]

2. Labecki, T D.: Proceedings Gerontological Society, Wash. D. C., Sept. 6, 1952.

3 liver is key organ

High incidence of liver dysfunction in diabetes, atherosclerosis, obesity and other degenerative disorders, emphasizes the need for a complete nutritional lipotropic (Methischol) regimen to improve liver function and thus favorably influence certain primary biochemical abnormalities. Such therapy "may ultimately be the key providing mankind with a comfortable, useful old age."[3]

3. Pomeranze, J.: Proceedings Gerontological Society, Wash. D. C., Sept. 7, 1952.

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TAYLOR INSTRUMENTS MEAN ACCURACY FIRST

regional plans have been financed by the Rockefeller and Kellogg Foundations and by the Commonwealth Fund. No permanent system of financing has yet been developed to pay for the many additional services these plans provide to both patients and doctors."

It's estimated that the recommended regionalization would cost $100,000 per region per year—at least at the start. These funds, the commission feels, should come from "a variety of sources—to prevent domination by any one group." Recommended sources: membership dues, gifts from voluntary agencies, grants from government at all levels.

If Doctors Object

Are there any arguments *against* regionalization? Yes, there are—and they're summarized thus: Some doctors fear the loss of certain privileges (for example, surgical privileges) that they've exercised when consultant services were unavailable. Some small hospitals fear domination by larger hospitals in their region. And some local citizens fear that regionalization may be a step toward state medicine.

It's felt that these arguments can be overcome—first, by planning *not* to take away privileges, but to help doctors measure up to them; second, by avoiding regional plans based on compulsion; third, by securing such strong local sponsorship that there's no chance of state dictation.

3. GOVERNMENT INTEGRATION. The trouble with government spending for health is that it's spotty, haphazard, inadequate. This diagnosis rises inevitably out of the panel findings:

Some $3½ billion a year in tax funds is now being spent for medical purposes—one-third of it by the Federal Government. "This mass of state medicine" (as one panel member called it) includes hospital construction, public health services, medical education, and indigent care. But only in the hospital field is there any real coordination.

Hill-Burton Boost

What happened in the hospital field? The Hill-Burton Act—with its preliminary surveys, its grass-roots planning, its required matching of Federal, state, and local funds. "These funds have had a salutary effect on hospital operations," Dr. Edwin Crosby told the commission. "They have already produced 1,000 new hospital facilities, with about 1,000 more in progress . . . This is a sound principle for dispensing Federal funds."

Signs are that the commission concurs—that it will recommend an extension of the Hill-Burton principle into other fields, including these:

¶ *New construction:* Something needs to be done about "antiquated and inefficient hospitals in urban areas," Dr. Crosby reported; and the Hill-Burton program might well be extended to include this. Capital financing for new medical groups is also on the commission's tentative list.

[MORE→

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But, basically, what caused Jenny to disappear? What's behind American industry's ever-more efficient machines that turn out goods at lower cost—thus making them available to more people? One word tells the story—COMPETITION.

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Competition—not government control—has already made America the most productive nation on earth. Competition—not regimentation—points the way to ever greater plenty for all of us.

★ ★ ★

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THE COMPETITIVE SYSTEM DELIVERS THE MOST TO THE GREATEST NUMBER OF PEOPLE

¶ *Regional organizations:* As noted previously, government support would be minimal here. Congress authorized $1 million for such purposes in 1949, but the Korean war kept the money from actually being spent.

¶ *Health departments:* About 50 million Americans live in areas that have no full-time public health services, the commission was informed. This problem can't very well be ignored—especially after Dr. Vlado Getting emphasized it thus: "The commission hasn't been thinking enough about how to reduce the risks of poor health . . . The greatest need in the United States is the development of these full-time local health departments."

What the Deans Want

¶ *Medical education:* Five years ago, medical school deans reported budget deficiencies totaling $30 million annually. By this year, they had secured $45 million annually in new operating funds. Yet a current survey reported by Dr. Ward Darley suggests that the schools are still $20 million a year short.

How come? Inflation, high taxes, and low interest rates tell the story; the new income doesn't stretch far enough, the deans say. Furthermore, they believe more *stable* financing is needed—income they can count on from year to year. And though they don't like the idea of government aid, they believe they can live with it.

State schools may be asked to look first to their state governments. But for private schools, the recommendation will probably include "Federal aid, on a continuing basis, free of Federal control."

Scholarship grants are another possibility. "If it takes ten to fourteen years before a physician is ready for independent responsibility," the panel concluded, "society should be willing to see to it that the potential of these years is not diluted out by impossible financial strain."

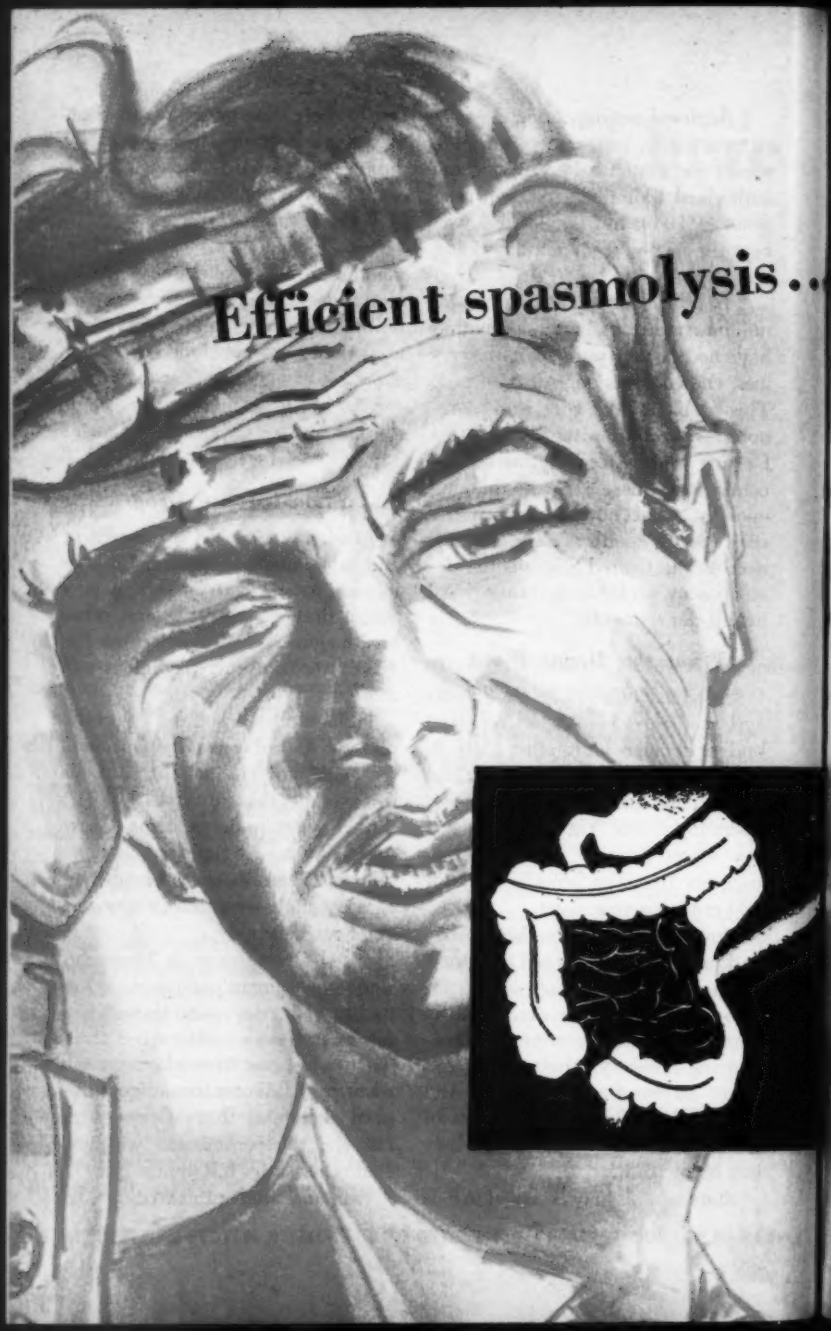
Low-Income Drag

¶ *Indigent care:* In the words of one panel member, services for low-income patients are "a serious economic drag on hospitals and other health agencies." Why? Because the government isn't paying its full share.

Philadelphia hospitals, for example, get $5 a day from government for each indigent patient. But, on the average, this care costs $13.61 a day. Paying patients, Blue Cross, and voluntary agencies have to make up the difference—even though such care is widely regarded as a government responsibility.

It's the same story in Massachusetts: government payments are limited to $12 a day, even though hospital care may cost twice that. There's just one state where government pays full cost for indigent hospital care, and that's Connecticut. Clearly, the commission will urge that other states fall in line.

Still unsettled at this writing is the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1. Dripps, R.D.: Selective Utilization of Barbiturates, J.A.M.A. 139:148 (Jan. 15) 1949.

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question of indigent *medical* care. While free clinics have their supporters on the commission, there's been some deprecatory talk about "poor man's medicine." It's likely, therefore, that the Hill-Burton pattern of financing will be recommended in modified form. Aim: to subsidize the low-income patient directly and without stigma.

4. HEALTH INSURANCE. At various times in the past, four commission members have spoken up in favor of full-scale compulsory health insurance (they are Walter Reuther, A. J. Hayes, Elizabeth Magee, and Dr. Dean Clark). Signs are that these four have won no converts on the commission. Signs are, in fact, that at least two have themselves been converted.

Not that they haven't heard all the arguments for national health insurance; Michael Davis, Isidore Falk, and Nelson Cruikshank have seen to that. But the commissioners have also heard plenty about voluntary insurance. They have learned it's entirely reasonable to assume that existing plans will prove "an effective economic tool . . . for the entire employed population and their dependents."

"Abbra cadaver."

Becker Changes Tune

This description stems from the testimony of Harry Becker. And that's important, because Becker has heretofore heaped scorn on the voluntary plans; in 1946 he testified in support of the Wagner-Murray-Dingell bill.

Even more important, Becker's boss in the United Auto Workers is none other than Walter Reuther. Today Becker says he's "convinced that voluntary health insurance can meet all reasonable yardsticks; it's done so already in some places." Tomorrow Reuther (along with the other commission members) is likely to say the same thing.

What *are* reasonable yardsticks for the voluntary plans? Low overhead, comprehensive benefits, and lay representation are three. But as evidence of "striking progress . . . toward meeting these criteria," Becker cites the Michigan Blue Cross plan: Only 4½ per cent of its income goes for operating costs; up to 120 days of full hospital care is provided per year; and Becker himself is a member of the plan's governing board.

They're Doing the Job

Other testimony received by the commission is along the same lines: Nearly 60 per cent of all Americans

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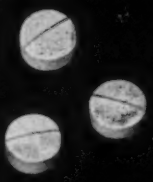

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now carry some form of health insurance; the number protected is growing at the rate of about 1 per cent a month. In relatively few years, hospital benefits have increased from twenty-one days' coverage to ninety or 120 days' coverage; surgical allowances, from $150 maximums to $350 and $500 maximums. And the plans are getting ready to broaden their coverage still more.

People over 65? "There's no good reason for not enrolling them," Dr. Charles G. Hayden, director of Massachusetts Medical Service, told the commission.

Prolonged illness? "The cost of physicians' services [in such cases] can be covered completely or almost completely by Blue Shield plans through a simple extension of benefits," Dr. Hayden held.

Home and office calls? "Such services seem to be insurable, provided the subscriber assumes the cost of . . . the first few calls in any illness," said George Cooley of the A.M.A.

Price-Tag Problem

As to whether such benefits can be offered at a salable price, the consensus seems to be: Competition will force it. And by way of relating subscription charges to the subscriber's income, more "double standard" plans may be recommended. For example:

Blue Shield in Massachusetts offers *two* service contracts—one with income limits of $3,000, the other with income limits of $5,000. Both contracts provide the same scope of benefits; but subscription charges and fees paid to doctors are higher under the second contract. "Because we permit subscribers to choose the plan that best suits their individual needs," Dr. Hayden reported, "we have succeeded in gearing our subscription charges to ability to prepay."

Two final recommendations wrap up the health insurance story. The commission believes that:

¶ Government workers should be permitted to arrange payroll deductions for voluntary health insurance. Private business allows and encourages this; the Federal Government, with 3 million employes, doesn't.

¶ Gyp insurance companies should be run out of the industry. Example: a hospitalization outfit in Pennsylvania that last year squandered 94 per cent of its income on overhead and commissions.

How It Adds Up

There you have the essence of the Magnuson Report. In summary, its main points can be crystallized thus:

1. Good health and good medical care are worth several billions more than the nation is now spending on them. Individuals, voluntary organizations, and government should all be encouraged to jack the ante.

2. General practitioners need more opportunity to work in hospitals, in closer association with specialists. G.P.'s also need more help from ancillary personnel.

3. Specialists need to work more

closely with each other and with G.P.'s—preferably through new group-practice units, which may require new capital financing.

4. Regional organizations are needed to help extend diagnostic, consultation, and educational services into the smaller towns.

5. All levels of government have a part to play in health. Their activities badly need coordination of the sort achieved through the Hill-Burton Act.

6. Greater emphasis on preventive medicine should begin with full-time public health departments covering the whole population—not just two-thirds of it, as at present.

7. Stronger support of medical education is a must. Since voluntary sources haven't provided the funds needed, government sources should.

8. Voluntary hospitals should be repaid *in full* for the free care they give low-income patients. The token payments now made by government are dangerously inadequate.

9. Voluntary insurance should be accepted as the basic mechanism for financing the medical care of all self-supporting American families.

10. Medical care for families that *aren't* self-supporting should be financed by government—probably using voluntary plans as intermediaries, but subsidizing the patients rather than the plans.

11. Voluntary plans should be given new goals to shoot at, including more efficient operation, more comprehensive benefits, and more consumer representation. END

Here is what the clinicians are reporting about NEO-PENIL*... the new derivative of penicillin

. . . about its ability to concentrate in the lung:

". . . concentrations of this drug in the lungs after intramuscular injection are five to ten times higher than that of benzylpenicillin [penicillin G]."[1]

. . . about its ability to concentrate in sputum:

"Neo-Penil gave rise to significantly higher concentrations of penicillin in bronchial secretions than did procaine penicillin . . ."[2]

"Procaine penicillin, in the same dosage, produces considerably lower sputum levels or fails to appear at all."[3]

. . . about its effectiveness in bronchopulmonary disease†:

"Our own evidence would indicate that it is a more effective form of penicillin in patients with chronic pulmonary emphysema and bronchopulmonary infection."[4]

"This compound appeared to have a unique value in respiratory infections due to gram-positive bacteria."[1]

"Prompt reduction or elimination of pus from the sputum occurred in 75 per cent of fifty patients with chronic bronchitis and bronchiectasis, with a comparable clinical improvement."[1]

†For additional evidence, turn to page 62

. . . about its ability to concentrate in other tissues:

". . . it is apparent that this compound possesses chemical or physical properties that bring about a higher concentration of penicillin than that brought about by procaine penicillin in: the erythrocytes and leucocytes of cats, in the lungs of dogs, and in bronchial secretions, spinal fluid, and umbilical cord blood of humans."[2]

. . . about its toxicity:

". . . the toxicity of the compound appears to be of the same order as that of procaine penicillin."[2]

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'Neo-Penil' is available at retail pharmacies, in single-dose, silicone-treated vials of 500,000 units.

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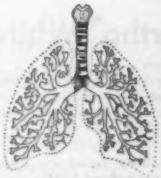

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Ortho Creme vaginal cream — ricinoleic acid 0.75%, boric acid 2.0%, sodium lauryl sulphate 0.28%.

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The Newsvane

Denies Hospital Profits Mean M.D. Exploitation

A salaried staff physician isn't necessarily "exploited" just because a hospital makes a profit on his services. At least that's the view of Dr. E. T. Wentworth, president of the Medical Society of the State of New York. He maintains that there's no reason for medical or specialty societies to regulate the financial arrangements made between hospitals and their staff specialists.

The A.M.A., says Wentworth, considers it "beneath professional dignity" for a doctor to supply his services to a hospital that collects fees for them. But, he insists, "It is really an economic, not an ethical, problem." So it's unreasonable, he adds, to deny ethical standing to physicians who work under such conditions.

Although organized medicine has abandoned its attempts to punish fee-collecting hospitals, there's still too much agitation for punitive measures against the physicians, according to a couple of Dr. Wentworth's editorials in recent issues of the New York State Journal of Medicine. "Are we ready to determine, labor-union-wise, the economic conditions under which every hospital specialist works?" he asks. "It seems to me I have heard that planned economy is in disfavor among physicians."

If hospitals *didn't* profit on staff specialists' work, he thinks, some "embarrassing situations" might be created. Where the specialist himself receives all payments, he "could and sometimes does underpay his staff" in order to increase his own income.

And if, to eliminate departmental profits, fees to patients were reduced substantially, "so much of the work of a community would be done in the hospital that the private practitioner would really be in economic trouble."

Wentworth advocates a system under which the specialist who feels that he's exploited can discuss the matter with his hospital administration. By thus airing their differences, he says, they can reach a settlement "without fear of disruption of relationships."

Asks Cost-of-Living Hike For Public Health Men

About four years ago, the American Public Health Association recommended a five-grade range of minimum salaries for public health physicians. It ran from $6,000 for new-

comers to a top minimum of $15,000 for doctors holding down posts of greatest responsibility.

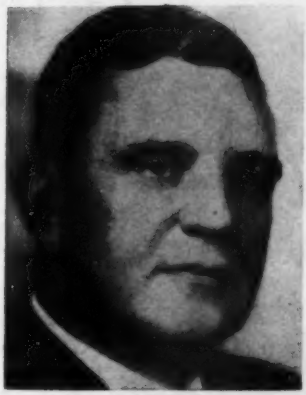
Since then, Korea has come—plus rocketing prices and a bigger tax bite. With inflation cutting the dollar down to a shadow of its old self, the association now recommends a higher range of minimums for public health physicians. The increase: 20 per cent across the board. The new minimums: $7,200 at the bottom, $18,000 at the top.

The A.P.H.A. emphasizes that these recommendations, if followed, will merely enable the public health physician "to hold his own economically—to maintain the same purchasing power he had before the Korean War."

Miners' Health Plan Asks Policing of M.D.'s

The country's biggest union medical program—served by private physicians in twenty-six states—isn't getting the best results. So says its executive director, Dr. Warren F. Draper. The United Mine Workers' $50 million welfare plan needs better policing of the doctors who serve it, he says.

Among the several thousand doctors caring for U.M.W. beneficiaries on a fee-for-service basis, reports Dr. Draper, there are some "whose motivations and qualifications . . . are such that the interests of the patient are not well served. The money paid them by the fund is largely wasted." Often the fund must "utilize the services of the incompetents," he adds, because of a doctor shortage in the mine fields.



Warren F. Draper
Trouble in mining medicine

The abuses thus generated include unnecessary surgery and "indiscriminate use of antibiotics," Dr. Draper charges. Efforts of the program's regional medical directors to bring about reforms through local medical society intervention, he says, have so far been unsuccessful.

Hospital X-Ray Charges Compared Across U. S.

What do hospitals charge for X-rays? A survey by the American Association of Hospital Accountants, covering 150 hospitals in all sections of the country, provides a rough yardstick of interest to private doctors who do their own X-ray work.

There's wide disparity in rates,

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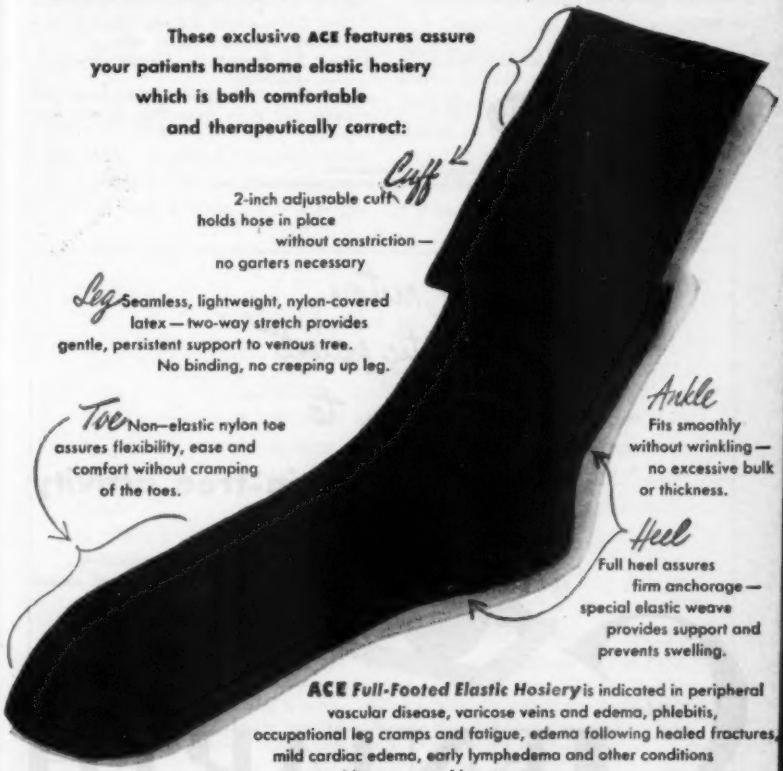

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Gentarth tablets also contain succinic acid to protect against increase in prothrombin time—a necessary precaution in prolonged salicylate therapy.

Each tablet contains:

Sodium Gentisate	100 mg.
Raysal . . . . . *(representing 43% Salicylic Acid and 3% Iodine in a Calcium-Sodium Phosphate buffer salt combination)*	325 mg.
Succinic Acid	130 mg.

Dosage: 2 to 4 tablets 3 or 4 times daily (after meals and before bedtime).

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1. *Boyd, L.J., Lombardi, A.A. and Svigals, C.: New York Med. College Bull.*, 13:91, *1950.*
2. *Meyer, K. and Ragan, C.: Med. Concepts of Card. Disp.*, 17:2, *1948.*
3. *Quick, A.J.: J. Biol. Chem.*, 101:475, *1933.*
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even within the same geographical area. According to the results of the study, published in Hospital Management, chest survey rates in hospitals in the Middle Atlantic states, for instance, range from a low of $1 to a high of $20.

In general, charges are higher in the bigger hospitals. Average rates in four sections of the country are shown in the accompanying table.

Americans Trained Abroad Pose Licensing Problem

Signs are that American students have been "flooding" foreign medical schools in the last three years—and that they'll soon come streaming back. When they do, they'll pose a tough problem for licensing officials. There are more than 1,100 such students—admittedly an incomplete count—says Dr. Francis R. Manlove, associate secretary of the A.M.A. Council on Medical Education and Hospitals.

A council survey for the academic year 1951-52 found American students enrolled in seventy-eight medical schools in twenty-one countries (not including Canada), according to Dr. Manlove. Swiss schools, with 363, accounted for nearly a third of the total; there were 222 in Spanish and 134 in Italian schools.

While some of the Americans undoubtedly wanted to study abroad,

X-Ray Charges in Hospitals

	New England	Middle Atlantic	Mountain States	Pacific Coast
Chest survey	$ 7.00- 9.50	$ 7.00-13.25	$ 7.00-12.00	$14.00-11.75
Chest*	11.00-14.00	11.00-14.75	9.25-12.00	13.00-15.50
Limb	7.50-10.00	11.00-11.00	6.75-10.00	13.25 10.50
Head	13.50-16.50	21.00-21.00	10.25-19.50	22.00-26.25
G. I. series	28.00-29.00	30.00-36.00	27.00-29.50	25.50-31.25
G. I. and G. B. series	38.00-43.00	35.00-43.50	39.75-41.50	41.25-43.00
G. I., Colon, G. B., I. V. Pyl. series	56.00-52.00	49.50-78.50	78.25-52.50	63.75-72.50
Pyelogram	19.50-21.50	24.00-25.00	23.75-21.00	22.50-22.50

First figure in each column is average charge in hospitals with 100 or fewer beds; second figure is average in hospitals with more than 225 beds. Source: American Association of Hospital Accountants, 1952. *Pulmonary, cardiac, etc.

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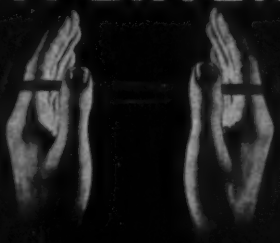

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TURASED provides rapid and prolonged reduction of blood pressure with lower serum levels of thiocyanate—thus increasing the margin of safety. Comparative clinical study[1] with TURASED has revealed "the infrequency of toxic or sensitivity reactions." In no case did capillary fragility become abnormal while the patient was receiving this preparation.

The potentiated, safer thiocyanate therapy made possible with TURASED is based upon the synergism offered by this original combination of ingredients.

1. Parsonnet, A. E., et al.: J. M. Soc. New Jersey 47: 504, 1950.

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Dr. Manlove observes, "others could not meet the academic requirements for admission in this country." He adds: "It is evident that the licensing authorities . . . will, for some time to come, be faced with a difficult task as they attempt to evaluate medical graduates returning to the United States."

Experts Urge Unlimited Medical Deductions

Congress should correct "an injustice in the Federal income tax law" by wiping out the present restriction on medical deductions, says tax expert J. K. Lasser. And Sylvia Porter, syndicated financial writer, joins him in this plea.

Present tax law, of course, rules that most patients can deduct only that portion of medical expenses that exceeds 5 per cent of their income. This, says Miss Porter, is an unnecessarily harsh limitation on the small wager-earner. And it's "brutally tough," she adds, "on taxpayers who have chronic illnesses in their families."

Lasser's main argument against the five-per-cent clause is that "medical expenses are job costs, ordinary and necessary if the individual is to produce the income that is to be taxed." Adds Miss Porter, indicating an analogy between the individual and business:

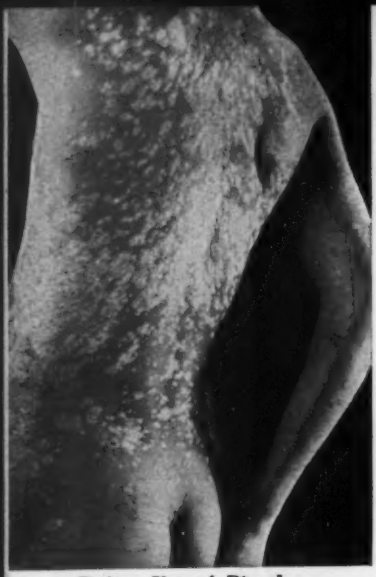
"A business can deduct all the expenses necessary to keeping the organization healthy—for instance, the cost of an accountant to keep the books in order, the cost of a cleaner to keep the office in order, etc. . . . that's a fundamental principle in the law. As such, it should apply to wage-earners too. They should be able to deduct all the expenses necessary to keep their 'organizations' (bodies) healthy."

Sylvia Porter
'Deduct all health costs'

Urges Doctors to Counter Letter-to-Editor Slurs

Because letters-to-the-editor departments of many publications contain criticisms of physicians, Charles P. Blair, council chairman of the Illinois State Medical Society, advocates a medical counter-offensive.

Most such letters complain of overcharging by doctors, he points out. So he urges medical men to make "some tangible effort . . . to curb the tendency of the press to



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"Then in the winter I used to go to the Caribbean, South America, Panama and other hot climates and lie in the sun. This caused the rash to disappear after I had a good tan. However, the rash came back after a time.

"Then I used Riasol and the rash has been gone for a long time with no return except for a small spot on my left elbow. This disappears after I apply Riasol a few times."

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RIASOL FOR PSORIASIS

malign the present-day doctor as a money-grabbing man."

Blair's suggestions:

¶ "Perhaps some concerted effort of our organization should be brought to bear on the editorial policy of such publications . . ."

¶ "The publication of a few articles by physicians [citing] incidents of the *humanity* of the doctor might help . . ."

¶ "Television programs may help . . . in showing the living-room audience just what the doctor . . . does for them at times *other* than when they are ill."

Most Medical Schools Finding New Funds

American medical schools have immensely expanded their facilities in the past three years. They've spent almost a quarter-billion dollars on new construction. And they've taken big strides toward improving their financial positions.

In reporting this news, the A.M.A. Council on Medical Education and Hospitals adds the following details:

¶ In 1952, the schools began new building projects totaling $60 million in cost. In the past three years, medical schools have spent over $241 million on construction work.

¶ For the sixth successive year, the schools report an increase in their total available funds. And their composite budget runs close to $81 million for the academic year 1952-53, exclusive of research grants and the like. This is about $6.5 million over last year's budget, and a jump of more than $13 million over that of two years ago.

Though income from tuition fees is on the rise, the percentage of the budget met by tuition is declining. Inflation has also wiped away some of the financial gains. Even so, the

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medical schools as a group are apparently working their way out of the financial doldrums.

Is this progress universal? Are *all* the schools sharing in it?

"On the contrary," asserts the A.M.A. council, "some schools have had a relatively enormous share of the funds, while others have had very little." A few, according to the council, "are still operating under the serious handicap of totally inadequate budgets."

In many such cases, the council puts the blame squarely on the institutions themselves: "They have either failed to develop programs that inspire confidence . . . or they have . . . not exerted themselves so vigorously or effectively as their sister institutions in their efforts to secure additional funds."

Pint-for-Pint Plan Called Best for Blood Banks

America's war-born blood banks have developed fast; but, as with any Topsy-like growth, there's still plenty of room for improvement. So says Dr. T. S. Kimball, chairman of the Los Angeles County Medical Association Committee on Blood Banks.

There are at present, Kimball reports, three types of banks:

1. The exchange type, in which the patient's family and friends replace the blood, pint for pint. A small service fee is charged, to cover costs of operation.

2. The straight sale type. Such banks buy blood and sell it outright to patients.

Theodore S. Kimball
Relocate blood banks?

3. The Red Cross Blood Center, which supplies blood free to hospitals and solicits replacement. The Red Cross supports this service with its own donated funds.

Of the three, says Dr. Kimball, the exchange type "is the one most suitable for the private practice of American medicine." But all of them, he adds, "have certain features of value."

What disturbs him is that the banks aren't always strategically located. Especially in the event of enemy attack, he notes, "it would be imperative to have more than one or two banks" in any given metropolitan area—an ideal not yet realized in many parts of the country.

In his own locale, he points out, "if the Red Cross bank were sud-


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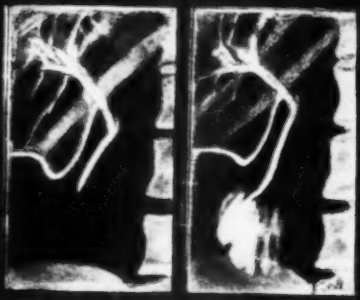

When spasm of the sphincter of Oddi (left) is relaxed (right), bile pours into the duodenum.

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Dehydrocholic acid, the most potent hydrocholeretic known, stimulates copious secretion of thin, free-flowing bile... increases volume output by as much as 190%... is the least toxic of any bile salt, bile acid, or their derivatives.

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Cholan-HMB contains, in addition to dehydrocholic acid-Maltbie, 250 mg. (3¾ gr.) per tablet, the spasmolytic *homa*tropine *methyl*bromide 2.5 mg. (1/24 gr.), and phenobarbital 8 mg. (⅛ gr.).

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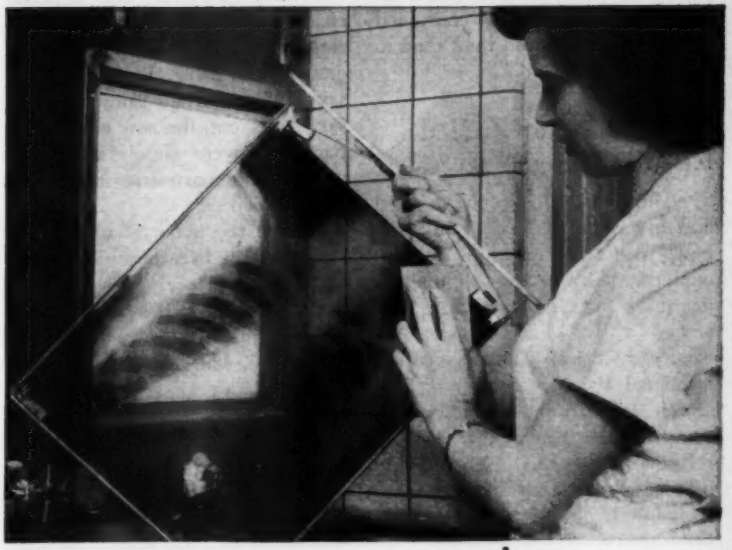
denly destroyed, it would take weeks to develop facilities for drawing blood adequate for casualties. With multiple banks, the likelihood of more than one . . . being destroyed at one time is remote, and the remaining banks could easily take up the slack."

In addition, he asks for less "tolerant antagonism" between the Red Cross and the medical profession. Such antagonism may lead to abuses of blood bank operations, he says, citing one instance of this in Southern California, where many hospitals and clinics obtain blood from the Red Cross. Recently, he says, it's been discovered that many patients have been billed for such blood "under one guise or another." He calls this practice "the lowest form of financial gouging."

In spite of such flaws, Dr. Kimball finds the present situation good. After all, he declares, a hundred transfusions are given today for every ten in 1940; and "the strange



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part of it is that there is less muss and bother and less time consumed in giving the hundred than used to be taken for the ten."

Full-Time Staff Called Key to Clinics' Success

The University of Chicago's medical and biological research center recently celebrated its twenty-fifth anniversary by proudly summarizing its achievements to date. The center (officially known as the University of Chicago Clinics) credited its signal success in teaching, research, and patient care mainly to one principle: It maintains a wholly full-time staff—"the first and only one of its kind in any medical school."

Freeing instructors from dependence on private practice was the first step undertaken when the center began, in late 1927. By this means, says a university-sponsored anniversary statement, the new clinical departments were closely integrated with older departments in the biological sciences.

Among the major results so far, the university lists these:

1. A yearly average of 180,000 patient visits to the out-patient clinics, plus 170,000 patient days and 36,000 baby days of hospitalization.

2. A total of 141 graduates now teaching in medical schools or engaged in medical research, out of 462 graduated up to 1942. (Nearly all the more recent ones are still tak-

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George William Curtis

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5236

ing graduate training or are in uniform.)

3. Recent and current expansion (including the $3.5 million Argonne Cancer Research Hospital being built with Atomic Energy Commission funds), which is increasing the number of patient beds from the original 200 to 740.

Accomplishments in research alone have justified the full-time staff idea, asserts the university. It recalls that, in the beginning, some medical men were dubious: "There was apprehension that the full-time practice of medicine by a large group might prove too formidable competition for the physician in private practice . . . Skepticism also existed as to the willingness of physicians of the top rank to forgo the larger income they could command from private practice for the full-time appointments on a salary.

"Developments ended the doubts within a short time. The clinics . . . did not interfere with local practice. Instead, the new institution became a center to which private physicians referred patients."

'We Specialize in G.P.'s,' Says This University

Medical schools have sometimes been accused of gearing themselves to turn out only specialists. But no such accusation can be leveled against the University of Tennessee. For more than a year now, it has been emphasizing a program designed to lead students into general practice—and to increase the effici-

ency of medical men already in family practice.

Its General Practice Office offers the following training to medical students:

1. A lecture program orients students toward general practice.

2. Students actually serve as physicians to specific families, under staff supervision.

3. Well before graduation, the neophyte G.P.'s work in a clinic that "simulates as nearly as possible the actual conditions of general practice."

Nor does the program stop there. At the interne level, young doctors in the emergency and admitting rooms of the medical center are supervised by a family physician. And fledgling doctors operate a seven-day-a-week service clinic, under the eye of the university's general practice staff.

The university also offers short post-graduate courses for G.P.'s. And active G.P.'s may serve for two weeks at a time in the wards and out-patient department.

To top it off, Tennessee's General Practice Office maintains a free location service, "designed to encourage young men to enter rural family doctor practice."

Study Shows Interest in Medicine by States

In what states are young people most interested in medical careers? A new study by Dr. Harold A. Davenport, assistant dean at Northwest-

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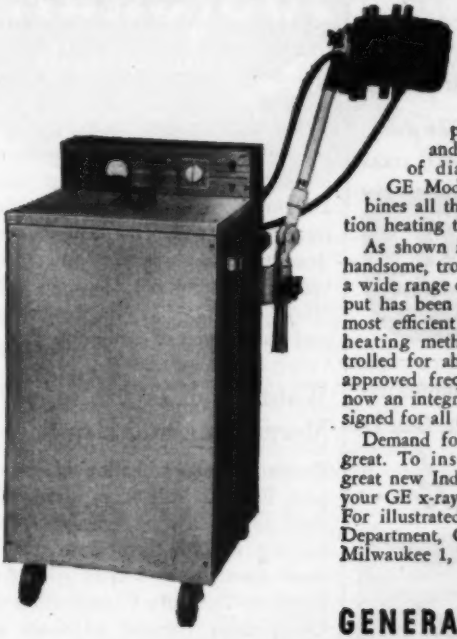

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Fully adjustable contour following electrode is part of the basic unit.

Optional is the 12 ft. treatment cable. Note how electrodes attach in rear.

Also available: fully adjustable air-spaced condensor type electrode.

ern University Medical School, indicates that New York tops the list. In the academic year 1951-52, about 22 New Yorkers per 100,000 population applied for admission to U.S. medical schools.

Next in order (with figures also based on applicants per 100,000 population) are: Utah and the District of Columbia, 21; Connecticut and New Hampshire, 18.5; Pennsylvania, 17.5; and Nebraska, 17.

The study reveals that Utah applicants show the highest acceptance rate—9.9 applicants out of each 100,000 population being admitted from that state to all medical schools. Acceptance figures for other top states: Nebraska, 8.4; Vermont, 7.2; North Dakota, 7.1; and Tennessee and the District of Columbia, 7.

Want a Job as Trolloper? Merrie England Has It

Despite the socialization of many jobs, England still offers a rich variety of fascinating employment—judging by the flavorsome names used. Fresh from a bout with the Registrar-General's Classification of Occupations (36,000 of them in

HANDITIPS

▶ **What nontechnical procedure or device have you found helpful in conducting your practice more efficiently? MEDICAL ECONOMICS will pay $5-$10 for original ideas worth passing on to your colleagues. Address Handitip Editor, Medical Economics, Rutherford, N.J.**

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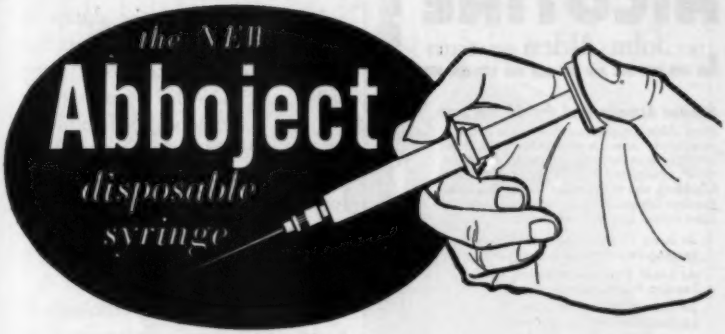

HERE is the ultimate in injection convenience for repository penicillin therapy. The new ABBOJECT syringe reduces preparation procedure to a minimum. Disposable, it saves time of cleaning and sterilizing; already filled, it eliminates handling of separate vials or cartridges, assures accurate dosage.

All you do is attach needle, as shown here, and the ABBOJECT is ready for immediate use. Unit is light, compact, easy to carry; new plastic construction rules out danger of breakage. The ABBOJECT may be assembled and carried in emergency bag without losing sterility if plastic sheath is left on needle. Also designed so that assembled syringe may be laid on table without contamination, as needle will not touch surface.

Containing the well-known repository product, ABBOCILLIN-DC, each syringe provides an accurate 600,000-unit dose of penicillin G procaine in aqueous suspension. With the high unitage and slow absorption of ABBOCILLIN-DC, penicillin blood levels adequate for the treatment of ordinary infections are sustained for 48 hours with a single injection. ABBOCILLIN-DC is now available at pharmacies in the new ABBOJECT disposable syringe, with or without sterile, 20-gauge needle.

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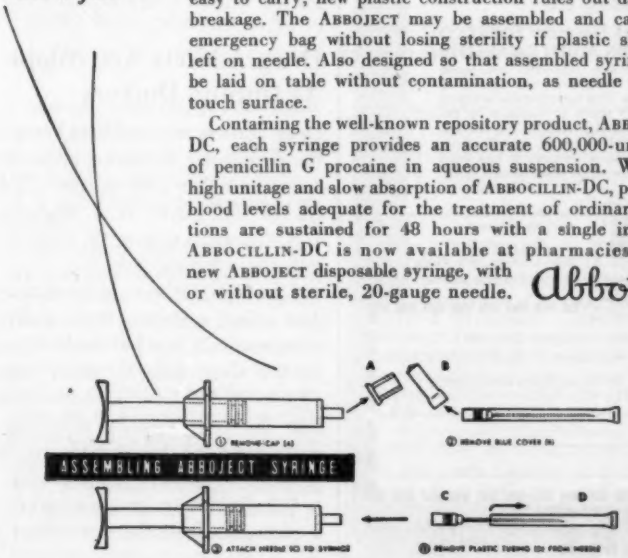

1950), an anonymous British physician points up this fact in a letter to The Lancet.

With no clue to the duties involved, the doctor nevertheless feels that a whimsical job-seeker might well investigate the chances of becoming a Trolloper, Whammeller, Nidger, Woffler, or Sagger Wad Pugman. Or, he adds, a more venturesome fellow might prefer a career as a Buttocker, Impregnator, Motion Minder, Night Smoker, or Idle Back Maker.

Having discovered, through research, that a Last Remover is not an undertaker but a worker in the leather trade, the bemused M.D. hopes to see a Dictionary of Occupations published soon. "Then," he writes, "I can find out whether a Bar Reeler will be the best part-time job for me when I retire."

Drug Addicts Are Adept At Duping Doctors

Drug addicts and peddlers know all the dodges for obtaining dope, and sometimes they cast doctors in the role of "fall guys." H. J. Anslinger, U.S. Commissioner of Narcotics, tells these typical stories:

¶ In New Orleans, a woman addict called a doctor from a drugstore and told him her husband and mother were suffering from severe attacks of diarrhea. The doctor fell into the trap and—by telephone—authorized the druggist to give the woman two ounces of laudanum.

¶ In Baltimore, an addict went to a physician, said he was about to

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Here's another good tip. Rub a little Noxzema on your feet some night when they're hot and tired after a hard day. See how cool and refreshing it feels, how much better *you* feel afterwards!

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enter an institution, but pleaded for one final shot, to calm his nerves. The doctor complied. The addict then came back again and again, each time with an elaborate alibi for delaying his departure. Only after four months did the physician catch on to the scheme.

¶ In a Texas city, an addict posed as a physician, telephoned several druggists, and asked them to rush narcotics to his office. He promised to have the required prescriptions ready on delivery. Then, continuing to pose as a doctor, he intercepted the messenger boys in the street outside the doctor's office, paid for the drugs, and promised to send in the prescriptions by mail.

Writing in the North Carolina Medical Journal, Anslinger winds up with these two prescription "don'ts":

1. Don't issue a series of postdated narcotics prescriptions to accommodate the patient when either of you is leaving town.

2. Don't sign blank prescription forms and leave them in the hands of an assistant.

Addicts and peddlers are ingenious, warns Anslinger. So a doctor's guard—like a prize fighter's—must be held high at all times.

Physicians Forum Scolds Social Security Critics

The Left-leaning Physicians Forum has bumped into some heated opposition to its campaign to have Social Security blanket private physicians. So far, says the Forum, it has received 300 letters from doctors on

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NEW! **Relay Action in One Tablet . . .**

You can now prescribe immediate-acting, sublingual aludrine (n-isopropylarterenol HCl) *and* the classic theophylline-ephedrine-phenobarbital anti-asthmatic triad in a single tablet. The asthma patient simply places a *Nephenalin* tablet under the tongue until the purple sugar coating is dissolved, then swallows the nucleus.

Aludrine (n-isopropylarterenol HCl) in the coating, absorbed sublingually, exerts pronounced bronchodilator action within 90 seconds. The nuclear combination of theophylline, ephedrine and phenobarbital is absorbed enterically to *relay* and *extend* the initial asthma relief for at least four hours. The average asthma patient may thus abort or suppress symptoms for a whole day with as few as three *Nephenalin* tablets!

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the subject; and fifty-six of these turned thumbs down—many with violence.

Here are some reactions reported in capsule form by the Forum:

¶ "Socialism," said eighteen physicians.

¶ "More taxes," said five.

¶ "Nuts," said four.

¶ "Malarky," said one.

Adds a report recently put out by the Forum: "Several asked if we were trying to ruin the American way of life; and . . . one doctor said: 'All of you should be kicked out of the A.M.A. and thoroughly investigated . . .' There was a complete lack of constructive comment or thinking on a plan which has operated for the benefit of millions of Americans for nearly twenty years."

Has Public Health Worked Itself Out of a Job?

Why is recruitment of public health physicians faltering? The American Journal of Public Health says that modest salaries are partly to blame. But far more important, it suggests, is the basic failure of public health to sell itself to doctors as a stimulating field of activity.

Says the journal: "If the task of the public health officer is merely to direct communicable disease control and community sanitation, the medical student of real caliber is eminently wise in concluding that this is no career for him. These were fascinating problems in 1900; they are fascinating problems in Asia and Africa and South America today. In

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these fields in the United States, however, what the health officer during the last fifty years has done is to work himself out of a job."

But, the journal insists, there are plenty of stimulating activities for the modern public health officer. Among them:

1. The study of home and street accidents;
2. Helping to assure good health in housing and city-planning projects;
3. Probing the subject of chronic disease;
4. Improving occupational hygiene;
5. Planning community clinics and hospitals;
6. Coordinating existing community facilities for medical care and planning new ones.

It's these unsolved problems "—and only the unsolved problems—which can attract young men and women with creative ability," concludes the journal.

Science Editor Assails Ban on Quoting M.D.'s

Despite A.M.A. encouragement of a more liberal attitude toward quoting doctors in the public press, some local societies still frown on the practice. So medical public relations suffer, says Arthur J. Snider, science editor of the Chicago Daily News.

At the recent A.M.A. Medical Public Relations Institute in Chicago, Snider described the swift eclipse of "a new era of mutual understanding" between doctors and the press,

PEDIATRICS BULLETIN

Prepared In The Interests Of The Profession By The Pediatrics Consultant Staff Of H. J. Heinz Company

Recognition of **FEVER** in children

LIKE MANY ELABORATE modern instruments, the ancient clinical thermometer, as you well know, is also often subject to abuse. Ignorance of normal variations of temperature has resulted in unnecessary invalidization of many children.

● **It is important** that we remember to correct the misinformation conveyed by the little red mark at 98.6. For we know that there is no single normal temperature level. There is a normal temperature range, varying in different children and at different times in the same child. It has been well established that emotional factors and fatigue may cause a rise of temperature to well above 100. We must also bear in mind that an acute illness may upset the nicety of the temperature regulating mechanism for several weeks after infection has quite subsided, particularly if restriction to bed is enforced. This can be very misleading to even the most careful physician worried about rheumatic fever as an example, because he may never find what he considers a normal temperature as long as he keeps his patient in bed.

● **It is well** for us to remember that a temperature elevation alone, unless it is well above 100, in itself is not indicative of disease.

NOTE: These bulletins are designed to help disseminate modern pediatrics knowledge to the general medical profession and will appear monthly in Medical Economics.

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Motility recordings from the small intestine (by the multiple-balloon intubation technic*)—plus controlled clinical observations—have demonstrated the superiority of natural belladonna alkaloids (as in Donnatal) over atropine alone, and over the newer synthetics, in relieving smooth muscle spasm with minimal side-effects.

Formula: Each tablet, each capsule and each 5 cc. (1 teaspoonful) of elixir contains hyoscyamine sulfate 0.1037 mg., atropine sulfate 0.0194 mg., hyoscine hydrobromide 0.0065 mg., and phenobarbital (¼ gr.) 16.2 mg.

*Kramer, P. and Ingelfinger, F. J.: Med. Clin. North Amer. 32:1227, 1948.

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Anecdotes

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inaugurated three years ago by the A.M.A. At that time a public relations committee of doctors was authorized by the Chicago Medical Society to supply "quotes" to the press on appropriate subjects.

The idea worked for a time. Then, says Snider, doctors on the committee began to clam up. "Some were being intimidated by the ethical relations committee. Some were being teased by their colleagues. As one doctor explained: 'Dr. X came up to me and said, "I read Snider's write-up on you [one small quote], but I didn't think it was complete. He forgot to say your office hours were 2 to 4 on Mondays, Wednesdays, and Fridays." '. . . The net effect . . . is that the medical public relations committee has become completely impotent."

From his own experience, Snider cites these examples of medical press relations in Chicago:

¶ Last spring, the Daily News ran a series of statements by people in all walks of life on "What My Religion Means to Me." The religious editor picked from the phone directory, at random, the name of a general practitioner in an underprivileged section of the city. The doctor made a statement, and Snider was asked to clear it with the medical society. "It was a beautiful expression of creed," Snider recalls. "I was . . . certain the medical society would . . . be eager to have it appear, because it was the kind of good public relations to be identified with." But the chairman of the society's ethical relations committee turned

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thumbs down, according to Snider, on the ground that publication "would attract patients" to the quoted physician.

¶ Struck by the number of doctors married to doctors, Snider thought he had an interesting "woman's page" story that the society would welcome for its public relations value. He talked it over with some of the M.D. wives, who approved. Not so the ethics committee. The doctors were in practice, the committee said, and it would give them a competitive advantage.

¶ Another story made the papers—but not without repercussions. As Snider tells it: "A plastic surgeon in Chicago—a man of wealth who needs more patients about as badly as a sailfish needs a diving suit—has for about eight years been packing up his staff of nurses and traveling to Stateville, the penitentiary . . . One day each week he does plastic surgery on the gross deformities of some of these men . . . When the press reported this humanitarian piece of work, the doctor was haled before the ethical relations committee. [The committee] deemed that the story got too much publicity . . . even though he had nothing to do with the display the newspaper editors gave it."

Public relations committees are trying to do a good job, Snider concludes, but they're being hamstrung by ethics committees. And he warns: "These two committees [must] sit down and arrive at some understanding."

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1. Tisdall, F. F., and Jolliffe, N., in Clinical Nutrition, New York, P. B. Hoeber, 1950, c. 23, p. 590. 2. Sealock, R. R., and Goodland, R. L.: Science *114*:645 (Dec. 14) 1951.

Memo from the Publisher

● When MEDICAL ECONOMICS began, back in 1923, it reached most of its readers without benefit of formal invitation. Thus it introduced to doctors the principle of "controlled circulation"—where a hand-picked audience automatically gets a magazine free of charge.

But in recent years, our circulation policy has been greatly refined. Since we're often asked questions about it, the following answers may be of some interest to you:

Who gets MEDICAL ECONOMICS? More than 132,000 physicians. All those in private practice and below retirement age are currently eligible to receive it without charge.

How do they get it? By requesting it in writing. Eligible physicians can get MEDICAL ECONOMICS gratis if they fill out, sign, and submit a special form every two years.

What percentage of all eligible physicians request it? Over 90 per cent. And many of the non-requesters receive it on some other basis. (For example, doctors in the early stages of private practice get MEDICAL ECONOMICS automatically; this is their introduction to M.E.)

Who else receives MEDICAL ECONOMICS? Top executives of medical organizations, health plans, and hospitals. The magazine also has an expanding paid circulation.

How can you publish a magazine like MEDICAL ECONOMICS *without charging everyone for it?* By gaining the readership of almost every prescribing physician, thus attracting medical advertisers who seek widest impact for their ads.

Wouldn't most of your readers be willing to pay a subscription charge? Undoubtedly, yes. In a recent sampling, the great majority of those who offered specific opinions said the magazine was worth at least $3 a year to them; one-third said it was worth $5 or more.

Then why haven't you required a subscription charge? Because thus far we haven't felt it was necessary, in view of the advertising revenue from nearly all major drug and equipment companies.

Conceivably, this could change. Rising production costs might someday outstrip the ability or willingness of our advertisers to pay those costs in their entirety. If that happened, we'd feel obliged to turn to subscription revenue. We'd do this rather than do without the funds necessary for a top-flight editorial job—the kind that *is* possible at present under our free-on-request circulation policy. —LANSING CHAPMAN

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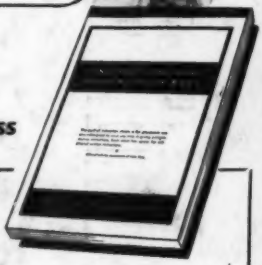

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